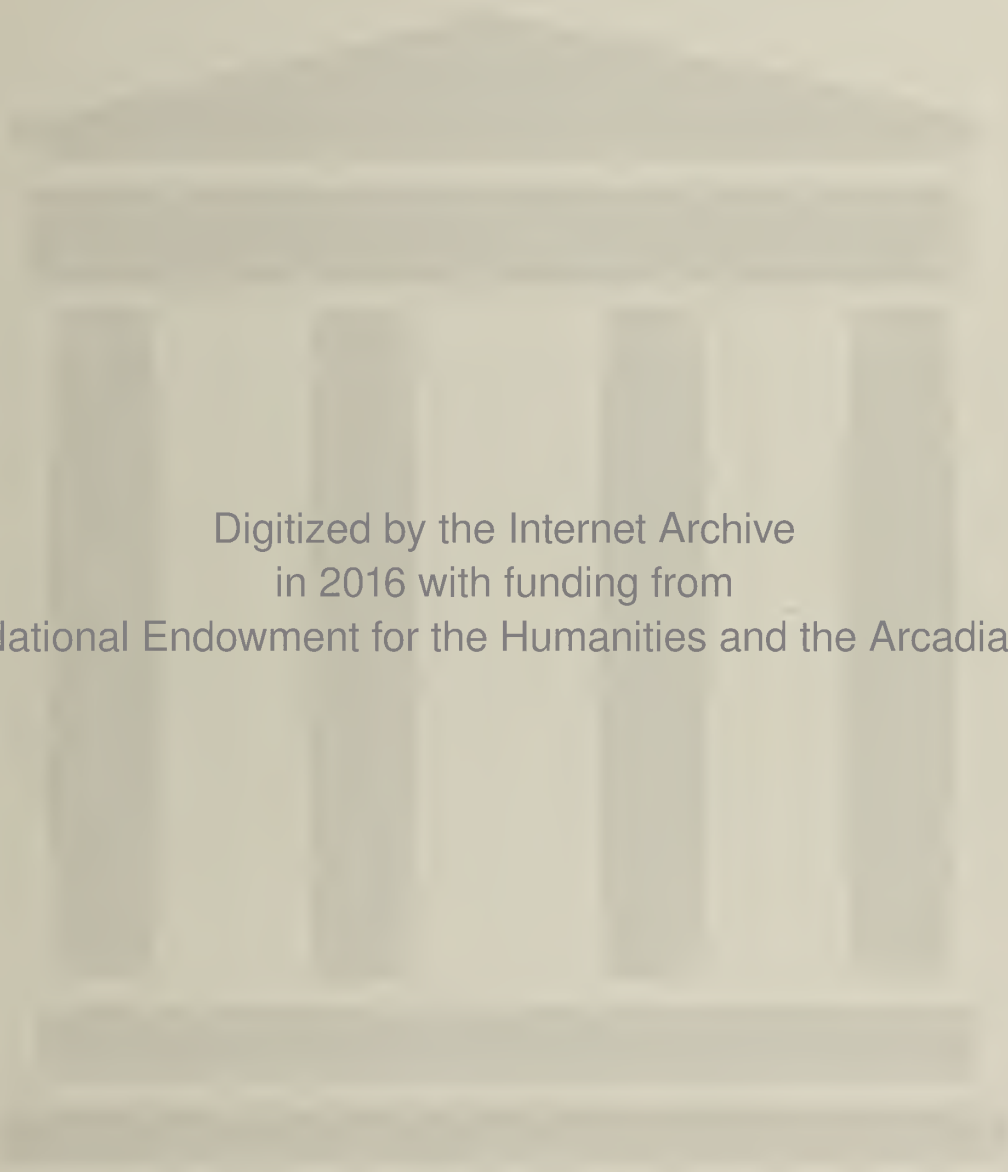


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STACKS

STATE MEDICAL

Journal

**Published By The Ohio State
Medical Association**

Featured in This Issue---

★ In the Scientific Section:

Evaluation of Stature in Adolescence,
and Other Clinical Papers

Beginning on Page 51

★ In the News and Organization Section:

Roundup on Taxes for the Physician,
and Other Timely Articles

Beginning on Page 75

(Turn to Page 3 for Table of Contents)

**1967 OSMa Annual Meeting
Columbus May 16 - 19**

JANUARY 1967
JUNE 63 ★ NUMBER 1

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The OHIO STATE MEDICAL Journal



VOL. 53 JANUARY, 1967 NO. 1

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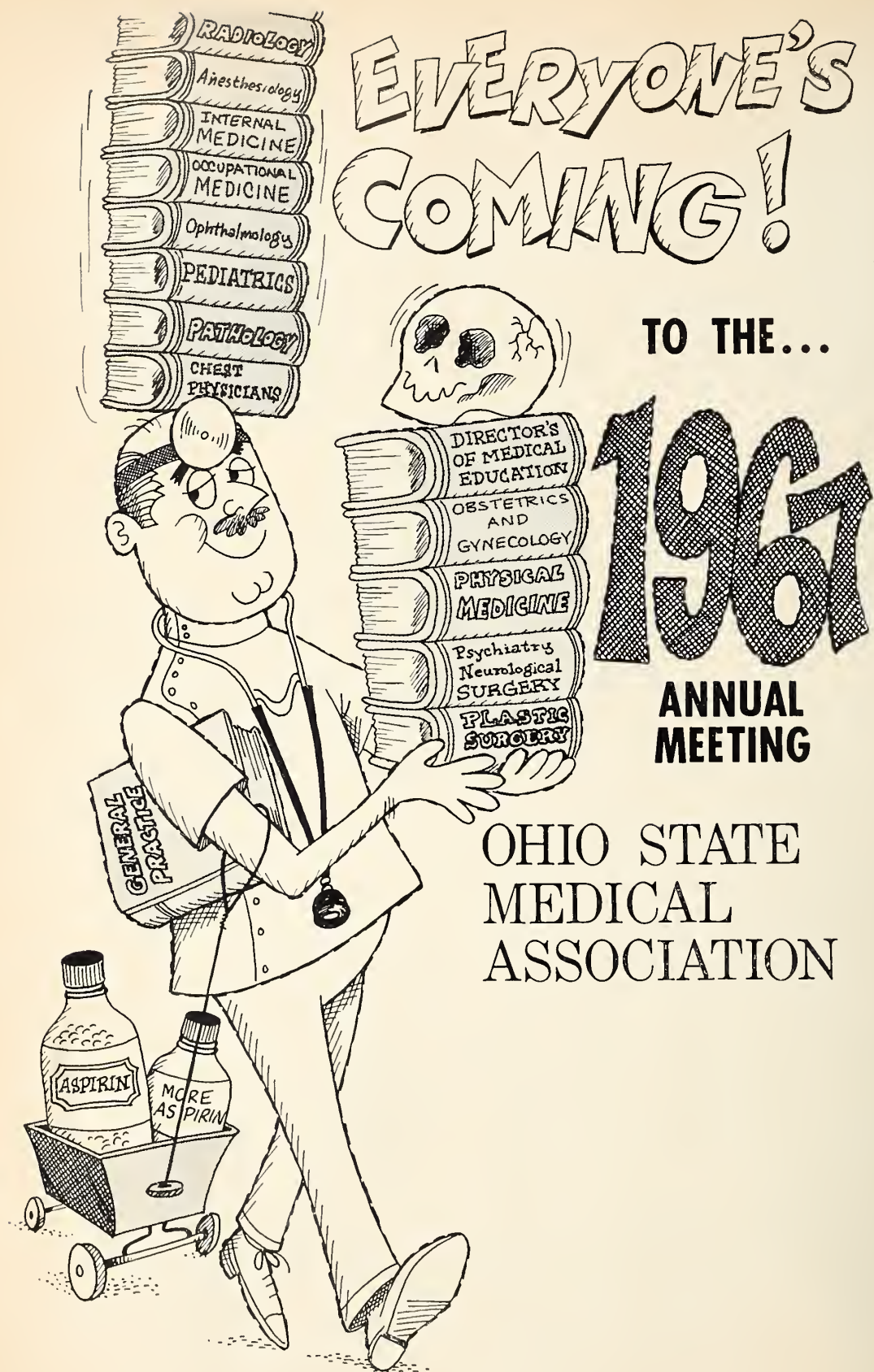
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EVERYONE'S COMING!

TO THE...

1967

**ANNUAL
MEETING**

OHIO STATE
MEDICAL
ASSOCIATION

1967 OSMA Annual Meeting...

Here Is a Resume' of Events and Gist of Topics For the Columbus Meeting Scheduled May 15-19

COLUMBUS will provide the setting for the 1967 Annual Meeting of the Ohio State Medical Association, with various events slated from the evening of Monday, May 15, through Friday afternoon, May 19. Most features are scheduled in the Sheraton-Columbus Motor Hotel, or in the Veterans Memorial Building.

More details on highlights of the meeting will be given in coming issues of *The Journal*, and the entire program, with topics, speakers, etc., will be published in the April issue.

Here is a resume' of the program:

Monday Evening, May 15

First Session of the OSMA House of Delegates, beginning at 8:00 P. M.

Tuesday Morning, May 16

Meetings of House of Delegates Reference Committees.

General Session — Auto Injuries — Program sponsored by the OSMA Section on Plastic Surgery and the Ohio Committee on Trauma, American College of Surgeons.

Tuesday Afternoon, May 16

Ohio Health Commissioners Institute.

Reception honoring exhibitors, hosted by officers of

the State Association and members of the OSMA House of Delegates.

Wednesday Morning May 17

Opening of Scientific, Health Education, and Technical Exhibits.

Continuation of House of Delegates Reference Committee hearings (if not completed on Tuesday).

Ohio Health Commissioners Institute.

General Session — Color Television Program Sponsored by the Ohio State University College of Medicine.

General Session—Sponsored by the Ohio State Heart Association.

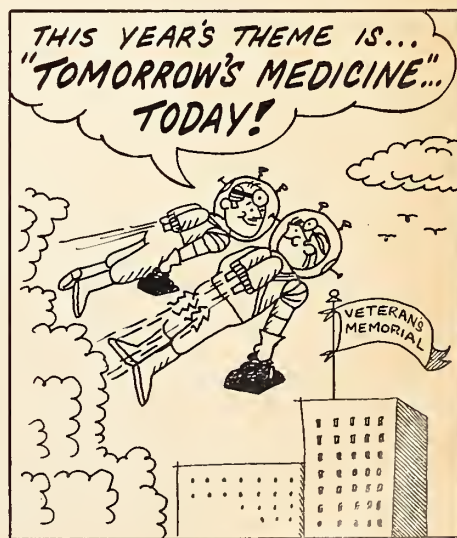
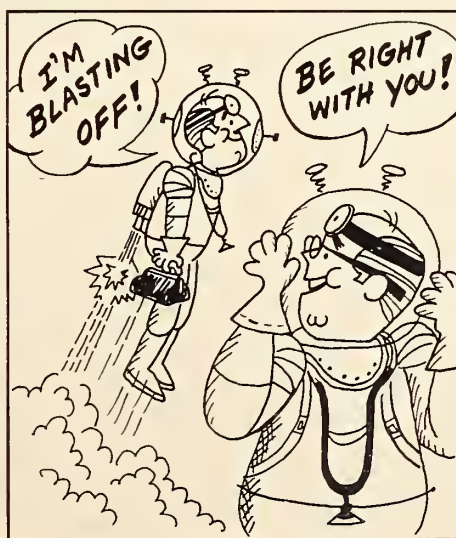
Wednesday Afternoon, May 17

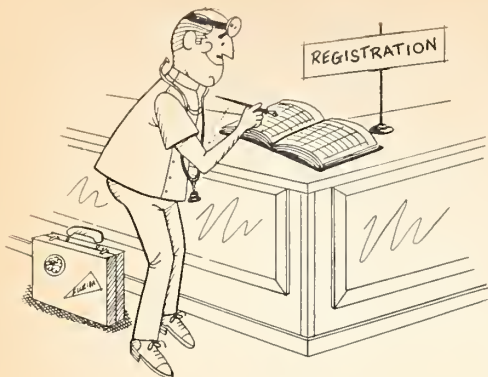
General Session — Teaching Physicians the Proper Method of Educating Patients Regarding Sexual Relationships. Program sponsored by the OSMA Section on Pediatrics and the Section on Obstetrics and Gynecology.

Section on Ophthalmology and the Ohio Ophthalmological Society.

Combined Meeting of OSMA Section on General Practice of Medicine, Section on Physical Medicine

(Continued on Page 7)





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(Continued from Page 5)

and Rehabilitation, and the Ohio Society of Physical Medicine and Rehabilitation.

Section for Hospital Directors of Medical Education.

Section on Internal Medicine, and the Ohio Society of Internal Medicine.

Ohio Health Commissioners Institute.

Thursday Morning, May 18

Executive Sessions of House of Delegates Reference Committees.

Ohio Health Commissioners Institute.

General Session — Color Television Program Sponsored by the Ohio State University College of Medicine.

General Session — Sponsored by the Ohio Division, American Cancer Society.

General Session — "Drug Regulations and Generic Prescribing," a panel discussion with James L. Goddard, M. D., Commissioner of the Food and Drug Administration, U. S. Department of Health, Education, and Welfare; C. Joseph Stetler, President, Pharmaceutical Manufacturers Association; and Max S. Sadove, M. D., Chicago, Assistant Professor of Anesthesiology, University of Illinois College of Medicine.

Section on Occupational Medicine.

Combined Meeting of Section on Pediatrics and Section on Obstetrics and Gynecology, Ohio Chapter, American Academy of Pediatrics.

Meeting of Section on Psychiatry and Neurology, and the Ohio Psychiatric Association.

Meeting of Section on Radiology and the Ohio State Radiological Society.

Ohio Health Commissioners Institute.

Thursday Evening, May 18

Gaslight Party for all OSMA Members and Guests.

Friday Morning, May 19

Final Business Session of the OSMA House of Delegates.

General Session — Color Television Program Sponsored by Ohio State University College of Medicine.

General Session — Computerized Medicine — Program Sponsored by OSMA.

Provisions in the OSMA Bylaws Pertaining to Nomination Of President-Elect

Attention is called to provisions in the Bylaws of the Ohio State Medical Association pertaining to the nomination and election of the President-Elect at the OSMA Annual Meeting. The President-Elect and other officers are elected by the House of Delegates, meetings of which will be held during the Annual Meeting in Columbus, May 15-19.

Nominations of the President-Elect are to be made 60 days in advance of the meeting at which election takes place and information on nominations published in *The Journal*, unless these provisions are waived by a two-thirds vote of the House of Delegates. The 60-day deadline is March 20.

The part of the OSMA Bylaws pertaining to this procedure is Section 1 (a), entitled "Nomination of President-Elect."

Friday Afternoon, May 19

General Session — Special Appearance of Milford O. Rouse, M. D., Dallas, Texas, President-Elect of the American Medical Association.

Section on Anesthesiology and the Ohio Society of Anesthesiologists.

Ohio Chapter, American College of Chest Physicians.

Section on Neurological Surgery and the Ohio Neurosurgical Society.

Section on Pathology and the Ohio Society of Pathologists.

Some Aphasic Patients Respond To Old Indian Sign Language

Veterans Administration researchers have developed two techniques which promise to help certain patients suffering from aphasia to communicate with the outside world.

One technique is based on the ancient Indian sign language; the other a simplification of conventional method of communication by deaf-mutes.

Some 3,000 aphasic patients in VA hospitals are unable to use the usual sign language or lip reading of patients who are deaf and dumb.

Dr. William E. Hunt, professor of surgery in the Ohio State University College of Medicine, has been reappointed chairman of the Scientific and Education Committee of the Congress of Neurological Surgeons for 1967.

APPLICATION FOR SPACE, SCIENTIFIC EXHIBIT, OHIO STATE MEDICAL ASSOCIATION, 1967 ANNUAL MEETING, VETERANS MEMORIAL BUILDING, COLUMBUS, OHIO, MAY 16 - 19

1. Title of Exhibit: _____

2. Name(s) of Exhibitor(s): _____

Institution (if desired): _____

City _____

3. Do you have a built-in exhibit? _____

4. Description of Exhibit: (Attach 200 word description to this blank for use in Annual Meeting Program)

5. Exhibit will consist of the following: (Check which)

Charts and posters _____ Photographs _____ Drawings _____ X-rays _____

Specimens _____ Moulages _____ Other material _____ (Describe)

6. Booth Requirements:

Amount of wall space needed? _____

Back wall _____ Side walls _____

Square feet needed? _____

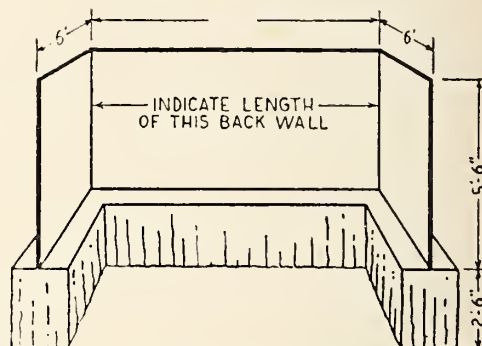
Shelf desired? (yes or no) _____

7. Transparency Cases:

Needed? (yes or no) _____

If answer "yes," give following information:

Number of transparencies to be shown and size of each _____



Booths will have a back wall and two side walls. The side walls of all booths will be six feet wide. Back wall and side walls are eight feet high. If standard shelf is used, only 5½ ft. will be available for exhibit material. For most exhibits, a back wall, eight feet long will be sufficient. With the two 6 ft. long side walls, this gives a total of 110 square feet of wall space.

(It is suggested that transparencies should be no larger than 10 by 12 inches in order to conserve space. For size of view boxes which will be supplied by the Ohio State Medical Association if requested by you and how films should be mounted, see pages 3 and 4 of folder "Regulations and Information, Scientific and Health Education Exhibits, Ohio State Medical Association" which will be supplied to all applicants.

Date _____

Signature of Applicant

Mailing Address, Street

City, State, Zip Code

SEND APPLICATION TO: COMMITTEE ON SCIENTIFIC WORK, OHIO STATE MEDICAL ASSOCIATION, 17 SOUTH HIGH STREET, SUITE 500, COLUMBUS, OHIO 43215

DEADLINE FOR FILING APPLICATIONS, JANUARY 30, 1967

M. D.'s in the News

Dr. Donald E. Walker, Cincinnati, spoke before the Northern Hills Mothers of Twins Club, using as his topic, "Making Sense Out of Sickness."

* * *

Dr. and Mrs. J. C. Willke, Cincinnati, led a dialogue with the Couples Class of the Chase Avenue Church of Christ in North Cincinnati, on the topic of sex education for children. They are authors of the book, *The Wonder of Sex: How to Teach Children*.

* * *

Dr. Robert A. Hingson, professor of anesthesiology at Western Reserve University School of Medicine, discussed medical conditions in Central America before a meeting of local Women's Medical Society in Cleveland. Dr. Hingson's observations were based on a tour of certain Central American areas as member of a medical team.

* * *

Dr. Hershel L. Clemmons, Hamilton obstetrician and gynecologist, discussed physiological aspects in use of "The Pill" before a meeting sponsored by the McCullough-Hyde Memorial Hospital Auxiliary in Oxford. Naomi Brown, dean of women at Miami University, discussed the same subject from the standpoint of moral issues involved.

* * *

Dr. Willis T. Kubiak, Columbus orthopaedic surgeon, spoke at a recent dinner meeting of the Fayette County Professional Nurses Association where he discussed the injuries and maladies in children requiring surgical treatment.

* * *

Three physicians discussed respectively "Three Phases of Eve" — endocrines, emotions, enhancement — at a meeting of the Women's Auxiliary of Mount Sinai Hospital, Cleveland. They were Dr. Milton Linden, Dr. Herbert Weiss, and Dr. Stanley Jaffe.

* * *

Dr. John P. Minton, Columbus, was principal speaker at the annual meeting of the Greene County Unit of the American Cancer Society in Xenia, where he discussed research at Ohio State University College of Medicine involving the effect of laser energy on cancer.

* * *

Dr. Mary L. Whitacre, Chesterhill, president of the Washington County Medical Society, was principal speaker at the annual meeting of the Noble County Unit, American Cancer Society.

* * *

Dr. Maceo R. Clarke, Dayton, has been reappointed as a member of the Ohio Board of Regents by Governor James A. Rhodes.

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Researchers at Ohio State Aided by Heart Funds

Nine new grants totaling \$39,641 from the Central Ohio Heart Association have been awarded to the Ohio State University College of Medicine for research.

Investigators who will share in the funds and their projects are:

Robert Gardier, Ph.D., and Saradindu Dutta, Ph.D., both of the Department of Pharmacology. Dr. Dutta is making studies of the uptake of radio-labeled cardiac drugs by the pig heart to determine proper dosages as related to the reasons for individual variations. Dr. Gardier is probing an enzymatic basis for the production of abnormal heart rhythms when cyclopropane anesthesia is used.

Charles V. Meckstroth, M.D., Department of Surgery, is conducting laboratory testing of an electronic heart pacemaker of new design. Also from surgery, John S. Vasko, M.D., is engaged in determining an uncomplicated and dependable index of heart muscle protection during open-heart surgery requiring artificial circulation of blood through the heart.

Five members of the Department of Medicine, including Robert Wall, M.D., received funds. Dr. Wall is investigating the "rebound hypercoagulability" which occurs in some patients following treatment with anticoagulant drugs. He will measure

blood-clotting proteins in these patients. Also in medicine, Richard F. Leighton, M.D., will use the electron microscope to determine effect of oxygen supply on the heart.

The project of Arnold M. Weissler, M.D., is to determine whether acidosis and other conditions resulting from coronary thrombosis cause still additional damage to the heart.

Clyde D. Schoenfeld, M.D., is studying the abnormal physiology resulting from heart muscle damage following myocardial infarction.

Willard S. Harris, M.D., is studying the mechanism of action of catecholamine on the human circulatory system.

New Service Coordinates Clinical Use of Radioisotopes by VA

The Veterans Administration has created a Nuclear Medicine Service to coordinate the clinical uses of nuclear energy in VA hospitals.

The new service, under the direction of Dr. Richard E. Ogborn, will systematize the use of radioisotopes to diagnose and treat some human diseases.

The VA actually began doing medical research with radioactive substances in 1947. Clinical uses of nuclear energy, developed as a by-product of this research, have been applied in VA hospitals for many years. Last year, the VA ran 77,000 diagnostic tests utilizing nuclear energy.

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Club Membership Technique Applied By GPs for Pap Test Follow-Up

The club membership incentive has been applied in a unique way by the Ohio Academy of General Practice toward a more faithful patient follow-up in the Papanicolaou Test program.

The Public Relations Committee of OAGP has introduced a card entitled "R. P. T. Club," which means Regular Pap Test Club. The card with the patient's name inserted and a date for her next test is presented at the time of the Pap Test.

Imprinted on the back of the billfold-size card are the following words: "Early recognition of cervical cancer is possible by this examination. For your health's sake keep your membership up to date. R. P. T. Club is a public service of the Ohio Academy of General Practice, 4075 North High Street, Columbus, Ohio 43214; Ohio's Family Physicians."

An estimated 14,000 women die needlessly of cervical cancer each year in the United States, according to figures quoted in announcing the project. Dr. Benjamin W. Gilliotte, president of OAGP, reported that the cards are available free to Academy members. Other physicians may order the cards at \$1.00 per hundred from the academy at the foregoing address.

Neurological Diseases and Blindness In Children Is Subject of Study

The National Institute of Neurological Diseases and Blindness has awarded a five-year \$210,000 renewal grant to Henry G. Cramblett, M.D., director of the Infectious Disease Service at Columbus Children's Hospital, and professor of pediatrics and professor and chairman of the Department of Medical Microbiology in the Ohio State University College of Medicine.

The grant will support continued studies of virus infections of the central nervous system in infants and children, particularly encephalitis and meningitis. The studies are aimed at learning more about the causes and after-effects of the infections.

Children participating in the studies are those treated for the diseases at Columbus Children's Hospital. They are seen in the Hospital, and on a long-term basis following discharge, to reveal what behavioral or neurological problems, if any, result from the infections.

A report on early findings, California Encephalitis Virus Infections in Children, was published in the October 10 issue in the *Journal of American Medical Association* under the authorship of Dr. Cramblett, Calvin Spencer, M.D., and Howard Stegmiller, of the Ohio Department of Health.

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6. Case histories on 4 patients.
7. Although psychotherapy still needed, role of chemotherapy cannot be disputed.

*"Sexual impotence treatment with methyl testosterone - thyroid (ANDROID) a double blind study" - Montesano, Evangelista: *Clinical Medicine*, April 1966.

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Current Comments in the Field Of the Drug Manufacturers

The following discussion is presented in behalf of the Pharmaceutical Manufacturers Association and drug manufacturing firms in general.

* * *

Prohibition-style racketeers, scenting millions of dollars in bootleg drugs, are beginning to invade the prescription drug market under cover of pressure for lower prices, Lyman C. Duncan, chairman of the board of the Pharmaceutical Manufacturers Association, said at a meeting of retail druggists.

A rising tide of "bootleg drugs" could impose a task on Food and Drug Administration agents as difficult as that of revenue agents searching for bootleg stills in Prohibition days, Mr. Duncan warned at the annual meeting of the National Association of Retail Druggists.

He said the protection once afforded doctors and their patients by the manufacturer's name on his products was "in danger of being demolished" by governmental action to promote the use of unbranded, and presumably cheaper, drugs.

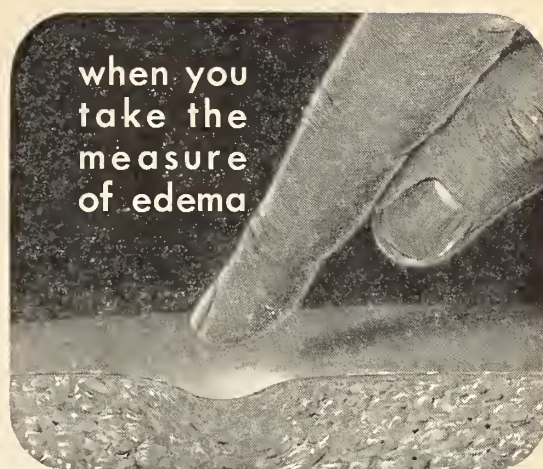
In the past, Mr. Duncan said, the chief requirement of an FDA inspector was technical knowledge of pharmaceutical products and manufacturing processes. The reliance on manufacturers' integrity "made it possible to police this vast industry successfully with a mere handful of technically-oriented FDA inspectors."

Now, with FDA's assignment of policing the potency, purity and safety of drugs, and the advent of "bootleggers," Mr. Duncan went on, the agency will require "pistol-packing investigators skilled in underworld procedures." He said they will have to search for the illicit and shady operators turning out complex and dangerous drugs in the industrial fringes of New Jersey and the outskirts of major cities such as Chicago and Detroit.

Mr. Duncan told the assemblage of retail pharmacists, "The illicit industry is still relatively small but the important thing is the seeds have been sown and the method of operation established. Their mushrooming growth only awaits the opening up of the vast new market which the campaign for generic prescribing will provide."

He said that many of the best known and most effective drugs in use today—steroids, antibiotics, diuretics and others—were the object of smugglers, counterfeiters and "all the illicit makers and purveyors of drugs of unknown and unspecified origin."

Now, with the brand-name lid off and the market potential of perhaps \$100 million, "the gentlemen who run the rackets and nefarious business enterprises in the United States are already well aware of the new opportunities that have been opened up for them in the field of pharmaceutical products," he said.



... introduce your patient to

aquatag[®]
(BENZTHIAZIDE)

AQUATAG (Benzthiazide) is a potent, orally active, nonmercurial, diuretic agent. It is effective orally in producing diuresis in edema states, where it is therapeutically comparable to mercurials given parenterally. AQUATAG (Benzthiazide) is mildly antihypertensive in its own right and enhances the action of other antihypertensive drugs when used in combination.

DIURETIC ACTION: Clinically, the oral administration of AQUATAG (benzthiazide) results in diuretic activity within two hours with maximal natriuretic, chloruretic, and diuretic effects occurring during the fourth, fifth and sixth hours. Maintenance of response continues for approximately 12 to 18 hours. Acidosis is an unlikely complication since therapeutic doses of AQUATAG (benzthiazide) do not appreciably increase bicarbonate excretion. Edematous patients receiving 50 mg. of AQUATAG (benzthiazide) daily for five days developed a maximal increase in the rate of sodium excretion on the first day, and maintained this high rate until depletion of excessive body stores of sodium.

In congestive heart-failure patients, AQUATAG (benzthiazide) produced the same weight loss during a 48-hour treatment period as did a maximally effective dose of hydrochlorothiazide.

DOSEAGE: Diuresis, initially 50 to 200 mg.; maintenance 25 to 150 mg., daily. Hypertension 50 to 100 mg. initially, adjusted to 50 mg. t.i.d. or downward to minimal effective dosage level.

WARNINGS: Use with caution in the presence of renal disease as azotemia may be precipitated or increased. In patients with advanced hepatic disease, electrolyte imbalance may result in hepatic coma. Dosage of coadministered antihypertensive agents should be reduced by at least 50%. In cases of suspected electrolyte imbalance, serum electrolyte determinations should be performed and imbalance, if any, corrected. Stenosis or ulcer of small intestine have been reported with coated potassium formulas, and surgery has been required and deaths have occurred. Based on surveys of both United States and foreign physicians, incidence of these lesions is low and a causal relationship in man has not been definitely established. Until further experience has been obtained, the use of the drug in pregnant patients should be weighed against possible hazards to the fetus.

CONTRAINDICATIONS: AQUATAG (benzthiazide) is contraindicated in progressive renal disease or dysfunction including increasing oliguria and azotemia. Continued administration of this drug is contraindicated in patients who show no response to its diuretic or antihypertensive properties. Severe hepatic disease is a relative contraindication. (See "Warnings" above.)

PRECAUTIONS AND SIDE EFFECTS: Electrolyte imbalance with hypokalemia (digitalis toxicity may be precipitated), hypochloremic alkalosis and hyponatremia may occur. Patients with cirrhosis should be observed for impending hepatic coma and hypokalemia. Other reactions may include blood dyscrasias, hyperuricemia and gout, nausea, jaundice, anorexia, vomiting, diarrhea, dizziness, paresthesia, photosensitivity and headache. Hepatic fetor, tremor, confusion and drowsiness are signs of impending pre coma and coma in patients with cirrhosis. Insulin requirements may be altered in diabetes. AQUATAG (benzthiazide) should be used with caution post-operatively as hypokalemia is not uncommon. Potassium supplementation may be advisable pre- and post-operatively. There have been occasional reports of thrombocytopenia, leukopenia, agranulocytosis, aplastic anemia and precipitation of acute pancreatitis or jaundice.

Before prescribing or administering, read the package insert or file card available on request.
Available as 25 or 50 mg. scored tablets.
Request clinical samples and literature on your letterhead.

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& COMPANY**
Detroit, Michigan 48234



Establish and maintain early, more decisive control of blood pressure

DIUTENSEN-R[®]

Cryptenamine 1.0 mg.* Methyclothiazide 2.5 mg. Reserpine 0.1 mg.

When blood pressure won't stay down despite initial therapy — when complaints of headache, fatigue or dizziness are often voiced — it may be time for a change to DIUTENSEN-R.

DIUTENSEN-R is thiazide and reserpine *plus* cryptenamine — a rational, comprehensive therapy to help establish and maintain early, more decisive control of blood pressure.

The cryptenamine in DIUTENSEN-R helps improve normal vasodilating reflexes while the thiazide and reserpine components maintain vasorelaxant, sedative, and saluretic benefits. Cryptenamine lowers pressoreceptor reflex thresholds (which may be abnormally high in hypertension) — "resets" pressoreceptors to function at more nearly normotensive levels.

Early, more decisive control with DIUTENSEN-R helps secure continuing benefits — may reduce or even obviate the need for poorly tolerated drugs later in therapy.

"...quite apart from the problem of vascular damage, there arises a possibility of virtual 'cure' or remission of hypertension when treatment is early, i.e., before too many other secondary pressor systems have entered into the disequilibrium of pressor control, and when it is adequately suppressive."

Corcoran, A. C.: The choice of drugs in the treatment of hypertension. In: *Drugs of Choice* 1966-67, W. Modell, Ed., St. Louis, C. V. Mosby Company, 1966, p. 417.

Indications: DIUTENSEN-R may be employed in all grades of essential hypertension.

Dosages: Usual dose is 1 tablet twice daily, at morning and evening meals.

However, adjustment of dosage to suit individual circumstances may be required. Please refer to package insert for full particulars. **Side effects and**

precautions: The side effects observed with patients on DIUTENSEN-R have been of a mild and nonlimiting nature. These include occasional urinary frequency, nocturia, nasal congestion, muscle cramps, skin rash, joint pains due to gout symptoms and nausea and dizziness which have been reported for the individual components. Most of these symptoms disappear while the drug is continued at the same or lower dosage level. The concomitant use of digitalis and DIUTENSEN-R may increase the possibility of digitalis-like intoxication. If there is evidence of myocardial irritability (extrasystoles, bigeminy or AV block), dosage of DIUTENSEN-R should be reduced or discontinued. Nocturia in patients with marginal cardiac status and salt and fluid retention can be effectively controlled by limiting the time of administration to early afternoon.

DIUTENSEN-R should not be used in patients with a known intolerance to reserpine. Package inserts furnish a complete summary of recommended cautions related to each of the ingredients of DIUTENSEN-R.

*As tannate salts equivalent to 130 Carotid Sinus Reflex Units.

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OMEN 1966-1967...

Ohio Medical Education Network, Originating at Ohio State Now Has Outlets in 54 Ohio and Neighboring-State Hospitals

THOSE CONCERNED with health problems are faced today with a growing challenge, namely, getting the findings and applications of medical research from teaching centers to the practicing physician and his patient. Here is a communication problem of the first magnitude. Journal articles and research reports lag behind the actual findings by as much as six months. The doctor frequently cannot leave patients to continue his education at a teaching center. Family physicians are swamped with reading material; some helpful, some useless, but much of it cannot be read due to lack of time. Time is a precious commodity for the patient as well as his physician.

To help meet this problem, the Center for Continuing Medical Education at the Ohio State University created the Ohio Medical Education Network which today is made up of over a dozen FM radio stations and 54 hospitals in Ohio, Pennsylvania, Kentucky, and West Virginia. Five times each week at 12 noon programs are broadcast which are "live" two-way discussions between home-community physicians and medical school teachers on subjects vital to continuing medical education.

The current academic year (1966-67) will raise the five-year attendance total to over 50,000, will bring to 700 the number of hospital staffs who have participated, and will see the 370th such program produced and broadcast. A highlight of OMEN's fifth anniversary year comes with being named recipient of the 1966 Creativity Award by the National University Extension Association's Division of Conferences and Institutes.

Over 100 hour-length programs are being broadcast this year concluding in April, 1967. Teaching physicians from five different medical schools in Ohio, New York and North Carolina will be heard talking with community physicians on such problems as shock, parathyroidism, proteinuria, hearing impairment, cardiac monitors, pediatric surgery, diverticulitis, ascites, anemias, hormones, lung dis-

ease, gout, and cancer. The immediacy of these programs and the fact that they can be heard by the general public help overcome the communications lag. Moreover, the program materials: slides, outlines, reprints and magnetic tapes all reinforce and extend the utilization of the programs into medical libraries and hospital teaching clinics.

Following broadcasts, the programs and slides are also made available on tapes in the OSU Autodidactic Laboratory in the College of Medicine for reference use by medical students and practicing physicians.

From Modest Start

Conceived in late 1961, the Ohio Medical Education Network came into existence in October 1962 with two FM radio stations broadcasting the two-way programs and involving 12 hospitals in Central Ohio. In four years, OMEN programs have resulted in some 38,000 registered attendances in network hospitals and an additional 12,000 to 15,000 are expected this year. Uncounted are the many physicians and the general public who listen in offices, homes, or automobiles.

WOSU-FM, radio outlet of OSU's Telecommunications Center is key station for the network, originating all programs and providing quality control in engineering and production.

Authorized for continuation study credit by the American Academy of General Practice, the network is supported in part by grants from the Merck Sharp and Dohme Postgraduate Program and the American Cancer Society. Across the country, the two-way technique is now being utilized by eight other medical institutions and serves participating physicians in 18 states. This is postgraduate training in the doctor's own hospital at the minimum of inconvenience and time lost from patient care.

A Look Ahead

Activities of the Ohio Medical Education Network have been broadened to include nursing and television. Successful experimentation in the Spring of 1966 applied the two-way audio technique to continuing nursing education. Using 12 OMEN hospitals and two FM radio stations, four pilot programs were developed by the School of Nursing and originated from WOSU-FM on campus. This nursing

This article was prepared for *The Journal* by William G. Pace, M. D., Assistant Dean of Ohio State University College of Medicine and Director of the Center for Continuing Medical Education, and by Robert B. Schweikart, Ph. D., Director of Communications at the Center.

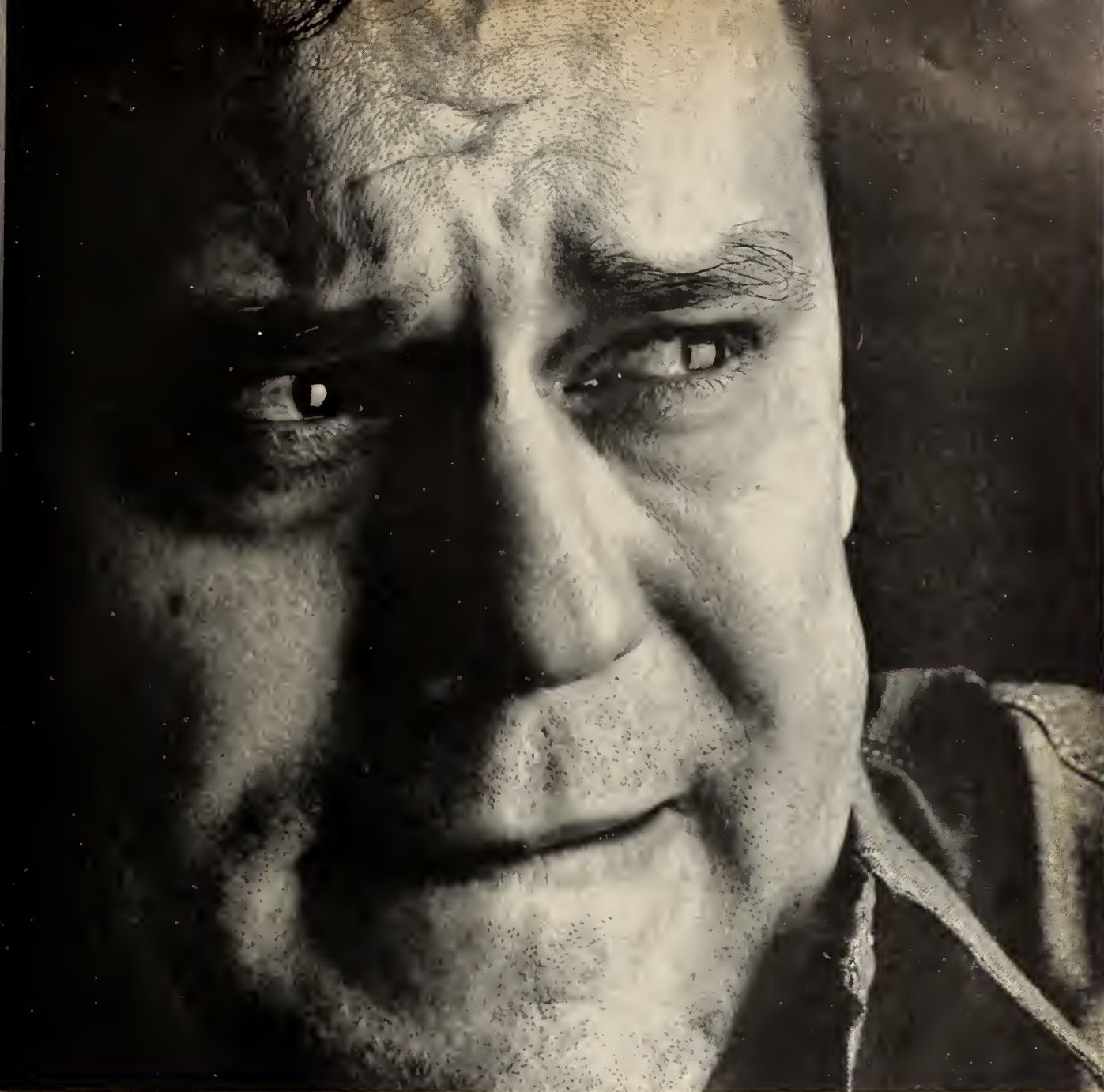


Photo professionally posed

Mike expects a penicillin injection. He's about to be pleasantly surprised.

His physician is going to prescribe an oral penicillin —PEN•VEE® K (potassium phenoxymethyl penicillin). It's usually so rapidly and completely absorbed that therapeutic serum levels are produced in 15 to 30 minutes. Higher serum levels generally last longer than with oral penicillin G.

Indications: Infections due to pathogens susceptible to oral penicillin G. Prophylaxis of rheumatic fever in patients with previous history of the disease.

Precautions: Skin rash, symptoms resembling those of serum sickness, or other manifestations of penicillin-allergy may occur. Measures for treating anaphylaxis should be readily available: epinephrine, oxygen and pressor drugs for relief of immediate allergic reactions; anti-

histamines and corticosteroids for delayed effects. Penicillin may delay or prevent the appearance of primary syphilitic lesions. Patients with gonorrhea who are suspected of concurrent syphilitic infections should be tested serologically for at least 3 months. Where lesions of primary syphilis are suspected, dark-field examination should precede use of penicillin. As with other antibiotics overgrowth of nonsusceptible organisms may occur; if so, discontinue and take appropriate measures. Treat β -hemolytic streptococcal infections with full therapeutic dosage for at least 10 days to prevent development of rheumatic fever or glomerulonephritis.

Contraindications: Infections caused by nonsusceptible organisms; history of penicillin sensitivity.

Composition: Tablets—125 mg. (200,000 units) and 250 mg., (400,000 units); Liquid—125 mg. (200,000 units) and 250 mg. (400,000 units) per 5 cc.

Wyeth Laboratories Philadelphia, Pa.

ORAL **PEN•VEE® K**
(potassium phenoxymethyl penicillin)



network will expand to ten programs, 24 hospitals, and three radio stations in January, 1967.

Moreover, three hour-length programs, characterized as "TV with two-way audio" have also been developed and carried on open-circuit television. Produced and broadcast by WOSU-TV and simultaneously broadcast by WGSF-TV (Newark, Ohio) and several Cable TV Services, the programs linked physicians in nearly a dozen OMEN hospitals scattered throughout Ohio with College of Medicine faculty for programs on the Neurological Examination, Congenital Hip Dislocation, and a Clinical Pathological Conference. Following a presentation portion, moderators in each hospital asked questions, using two-way audio techniques and equipment, of members of the program panel who were visible on TV sets. Plans are currently being studied for future use of the "TV with two-way audio" technique in continuing medical education.

Interesting Background Discussions Given on Chronic Inebriates

"The term, Skid Row, appears to have originated in Seattle at the turn of the 20th Century. Yessler Street, which sloped to Puget Sound, was greased and logs were skidded down the street into the Sound. Along this Skid Road were many taverns, cheap amusement places, and hotels which were frequented by the males who came to Seattle during the log shipping season.

"Seattle's Yessler Street formed the prototype of Skid Rows which are found throughout the Western World today . . ."

Taken somewhat out of context, this excerpt is part of a group of serious discussions under the title "The Court and the Chronic Inebriate." Published in pamphlet form by the U. S. Department of Health, Education, and Welfare, the booklet is for sale by the Superintendent of Documents, Government Printing Office, Washington, D. C. 20402 — price 35 cents.

WHAT TO WRITE FOR

Diagnostic Implications of Primary Amenorrhea — (Vol. 65, No. 4, October 1966). Reprints of the proceedings of a Combined Clinical Staff Conference published in *Annals of Internal Medicine*. Available to interested physicians on request from Clinical Center Information Office, National Institutes of Health, Room 1-N-248, Building 10, Bethesda, Md. 20014.

* * *

Medical and Surgical Motion Pictures — The AMA's catalogue of selected medical and health films, primarily directed to those concerned with education of medical students, interns, residents, physicians in all specialties, and participants in fields of allied medicine. Copies available without charge from the Medical Motion Picture Section, Department of Postgraduate Programs, American Medical Association, 535 N. Dearborn Street, Chicago, Illinois 60610.

* * *

Advice to Authors — Guide to preparation of manuscripts submitted to *The Journal of the American Medical Association* and the AMA Specialty journals. This 25-page illustrated pamphlet also makes an excellent guide for preparation of manuscripts in general, although each publication has its own style in regard to details. Fifty cents per copy in the U. S. and possessions, from the AMA, Order-Handling Unit, 535 N. Dearborn Street, Chicago, Illinois 60610.

* * *

Proportion of Surgical Bill Paid by Insurance. One of a series of U. S. Public Health Service pamphlets, being a summary and statistical report based on household interviews. PHS Publication No. 1000-Series 10, No. 31; for sale by the Superintendent of Documents, U. S. Government Printing Office, Washington, D. C. 20402; price 35 cents.



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plus important supportive benefits that help her through those critical early months of oral contraception

low incidence of side effects

Low incidence of BTB and spotting, nausea and amenorrhea tends to minimize side effect problems and increases patient cooperation.

no confusion about dosage

An unbreakable "confusionproof" package makes it easy to adhere to prescribed dosage schedule: individually sealed tablets numbered from 1 through 20 *plus* monthly calendar record enables patient to double-check dosage intake by day and corresponding tablet number.



Contraindications: Thrombophlebitis or pulmonary embolism (current or past). Existing evidence does not support a causal relationship between use of Norinyl and development of thromboembolism. While a study which was conducted does not resolve definitively the possible etiologic relationship between progestational agents and intravascular clotting, it tends to con-

firm the findings of the Ad Hoc Advisory Committee appointed by the Food and Drug Administration to review this possibility. Cardiac, renal or hepatic dysfunction. Carcinoma of the breast or genital tract. Patients with a history of psychic depression should be carefully studied and the drug discontinued if depression recurs to marked degree. Patients with a history of cerebral vascular accident.

Warning: Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn.

Precautions: By May 1963, experience with norethindrone 2 mg.—mestranol 0.1 mg. had extended over 24 months. Through miscalculation, omission or error in taking the recommended dosage of Norinyl, pregnancy may result. If regular menses fail to appear and treatment schedule has not been adhered to, or if patient misses two menstrual periods, possibility of pregnancy should be resolved before resuming Norinyl. If pregnancy is established, Norinyl should be discontinued during period of gestation since virilization of the female fetus has been reported with oral use of progestational agents or estrogen. When lactation is desired, withhold Norinyl until nursing needs are established. Existing uterine fibroids may increase in size. In metabolic or endocrine disorders, careful clinical preevaluation is indicated. A few patients without evidence of hyperthyroidism had elevated serum protein-bound iodine levels, which in the light of present knowledge, does not necessarily imply hyperthyroidism. Protein-bound iodine increased following estrogen administration. Bromsulphalein retention has occurred in up to 25% of patients without evidence of hepatic dysfunction. Studies from 24-hour urine collections have shown an increase in aldosterone and 17-

ketosteroids and decrease in 17-hydroxycorticoid levels. Thus, Norinyl should be discontinued prior to and during thyroid, liver or adrenal function tests. Because progestational agents may cause fluid retention, conditions such as epilepsy, migraine and asthma require careful observation. Thus far no deleterious effect on pituitary, ovarian or adrenal function has been noted; however, long-range possible effect on these and other organs must await more prolonged observation. Norinyl should be used with caution in patients with bone, renal or any disease involving calcium or phosphorus metabolism. **Side Effects:** Intermenstrual bleeding; amenorrhea; symptoms resembling early pregnancy, such as nausea, breast engorgement or enlargement, chloasma and minor degree of fluid retention (if these should occur and patient has not strictly adhered to medication plan, she should be tested for pregnancy); weight gain; subjective complaints such as headache, dizziness, nervousness, irritability; in a few patients libido was increased. In a total of 3,090 patients, 2.2% discontinued medication because of nausea.

NOTE: See sections on contraindications and precautions for possible side effects on other organ systems.

Dosage and Administration: One Norinyl tablet orally for 20 days, commencing on day 5 through and including day 24 of the menstrual cycle. (Day 1 is the first day of menstrual bleeding.)

Availability: Dispensers of 20 and 60 tablets; bottles of 100.

References: 1. Council on Drugs. JAMA 187:664 (Feb. 29) 1964. 2. Brvans, F. E.: Canad Med Ass J 92:287 (Feb. 6) 1965. 3. Goldzieher, J. W.: Med Clin N Amer 48:529 (Mar.) 1964. 4. Cohen, M. R.: Paper presented at Symposium on Low-Dosage Oral Contraception, Palo Alto, Calif., July 15, 1965. Reported in Med Sci 16:26 (Nov.) 1965. 5. Hammond, D. O.: Ibid. 6. Rice-Wray, E., Goldzieher, J. W., and Aranda-Rosell, A.: Fertil Steril 14:402 (Jul.-Aug.) 1963. 7. Goldzieher, J. W., Moses, L. E., and Ellis, L. T.: JAMA 180:359 (May 5) 1962. 8. Kemper, R. D.: GP 29:88 (Jan.) 1964. 9. Tyler, E. T.: JAMA 187:562 (Feb. 22) 1964. 10. Rudel, H. W., Martinez-Manautou, J., and Maqueo-Topete, M.: Fertil Steril 16:158 (Mar.-Apr.) 1965. 11. Flowers, C. E., Jr.: N Carolina Med J 25:139 (Apr.) 1964. 12. Goldzieher, J. W.: Appl Ther 6:503 (June) 1964. 13. The Control of Fertility. Report adopted by the Committee on Human Reproduction of the American Medical Association. JAMA 194:462 (Oct. 25) 1965. 14. Flowers, C. E., Jr.: JAMA 188:1115 (June 29) 1964. 15. Merritt, R. I.: Appl Ther 6:427 (May) 1964. 16. Newland, D. O.: Paper presented at Symposium on Low-Dosage Oral Contraception, Palo Alto, Calif., July 15, 1965. Reported in Med Sci 16:26 (Nov.) 1965.

norethindrone—an original steroid from
SYNTEX
LABORATORIES INC., PALO ALTO, CALIF.

Norinyl® tablets

(norethindrone 2 mg. • mestranol 0.1 mg.)

for multiple contraceptive action

Health Officers of Cincinnati, Ohio And the Problems of Their Day

1900 to 1960

KENNETH I. E. MACLEOD, M. D., M. P. H.*

PART VII

(Continued from December Issue)

Public Health Federation and Health Exposition, 1921

DURING the week of October 15-22, 1921, the Cincinnati Public Health Federation and allied organizations presented the First Health Exposition, with a combination of more than a hundred organizations participating. This was held in Music Hall.

On the Health Exposition, Dr. Peters wrote:

Two million people are directly interested in this Exposition. Other millions throughout the country will learn of it. The display lasts but eight days. Its memory, its joys, and its lessons will last for years . . .

On dental health he noted that

even "movie" fans will find a novelty on the screen at Music Hall on Thursday evening, October 20, 1921. A dental moving picture will be shown and a lecture explaining it delivered . . .

And shades of the radiation problem,

Thousands of Cincinnatians will have the opportunity of seeing for the first time what radium looks like. Two grams of the precious substance will be placed on exhibition by the Radium Chemical Company of Pittsburgh. [This was at the Exposition.] At the present time there are only 140 grams (or about five ounces) of radium in the world. The amount to be shown in Cincinnati will be approximately one sevenieth of the world's total supply. It will be a distinctly "Made in America" product, worth about \$250,000. The one gram less than a thimbleful which was presented to Madame Curie on her recent visit to the United States, cost over \$100,000 . . . [But one wonders what precautions were taken, if any, to protect the viewers and handlers?]

The Board of Health's exhibit at the Exposition occupied part of the South Wing of Music Hall and included a

well-equipped modern laboratory, booths devoted to the portrayal of the latest methods observed in the control of communicable diseases, the elaborate recording of vital statistics, improved sanitary methods in the control of the environment of food, milk and drugs; tuberculosis and venereal disease control systems; maternal and child health care; and other such items. Pictures of this exhibit appear in the

issue for November 10, 1921. For this it received the first award for the best educational exhibit. [Facsimile on page 4 of this same issue.]

Vital Statistics — 1922

And that health endeavors were beginning to pay off we note his remarks in the issue for January, 1922: A view of the vital statistics shows that Cincinnati's death rate for 1921, per 100,000 population is 14.1, the lowest in the history of the Queen City. The Cincinnati Health Exposition taught people to think in terms of better health.

Smallpox Scares

As we scan these reports during those years, we see the occasional threat of smallpox, as in 1922 when a section of Cumminsville was so threatened, "where vaccination has been conspicuous by its rarity . . ."

Negro Health

The week of April 2 to April 8, 1922, was recognized as "National Negro Health Week," and this "will indeed have been worthwhile"; Dr. Peters writes "if we shall have distilled in the minds of the colored people the importance and necessity of cultivating health habits every day of the year . . ."

V. D. Control

The year 1922 was also noteworthy because of the "All-American Conference on V. D." which was held in Washington, D. C.

Lack of Funds — A Problem

The trials and tribulations of the Department in maintaining the Dental Clinics are noted when "lack of funds caused the discontinuance of two chairs . . ." Dr. Peters noted,

We are all committed to the general plan of extending the educational work in the schools, but we believe that more would be gained by delaying the employment of an executive secretary until the city is in better shape to finance the operation of the free clinics . . .

Annual Outing

And that all is not work and no play in the Department, it is noted that the "annual outing" of the

*Dr. Macleod, Cincinnati, is Commissioner of Health, City of Cincinnati.

Submitted March 16, 1966.

Look how many ways

Thorazine®

brand of

chlorpromazine

can help

	Tranquilizer	Potentiator	Antiemetic
Agitation	●		
Alcoholism	●		●
Anxiety	●		
Cancer patients	●	●	●
Severe neurodermatitis	●		
Drug addiction withdrawal symptoms	●		●
Emotional disturbances (moderate to severe)	●		
Nausea & vomiting	●		●
Neurological disorders	●		
Obstetrics	●	●	●
Pain	●	●	●
Pediatrics	●	●	●
Porphyria	●	●	
Psychiatric disorders	●		
Hiccups—refractory	●		
Senile agitation	●		
Surgery	●	●	●
Tetanus	●	●	

'Thorazine' is useful as a specific adjuvant in the above named conditions.

The following is a brief precautionary statement. Before prescribing, the physician should be familiar with the complete prescribing information in SK&F literature or PDR. **Contraindications:** Comatose states or the presence of large amounts of C.N.S. depressants. **Precautions:** Potentiation of C.N.S. depressants may occur (reduce dosage of C.N.S. depressants when used concomitantly). Antiemetic effect may mask other conditions. Possibility of drowsiness should be borne in mind for patients who drive cars, etc. In pregnancy, use only when necessary to the welfare of the patient. **Side Effects:** Occasionally transitory drowsiness; dry mouth; nasal congestion; constipation; amenorrhea; mild fever; hypotensive effects, sometimes severe with

I.M. administration; epinephrine effects may be reversed; dermatological reactions; parkinsonism-like symptoms on high dosage (in rare instances, may persist); weight gain; miosis; lactation and moderate breast engorgement (in females on high dosages); and less frequently cholestatic jaundice. Side effects occurring rarely include: mydriasis; agranulocytosis; skin pigmentation, lenticular and corneal deposits (after prolonged substantial dosages).

For a comprehensive presentation of 'Thorazine' prescribing information and side effects reported with phenothiazine derivatives, please refer to SK&F literature or PDR.

Smith Kline & French Laboratories 

Cincinnati Health Department was held at Highland Grove on June 22, 1922 and "fun was had by all."

Health Officer and Politics

And a feeling article on "public health in politics" is quoted in the issue for September 10, 1922. This article was published in the CINCINNATI ENQUIRER. It states among other things that the Health Officer should be regarded as the most important functionary in the community service. His policies and suggestions should be matters of vital political consideration. The public should share duty and responsibility with him to the end that the community's best may be served . . .

Private Water Supplies

A matter of interest and concern in those days were the private water supplies in the city. It is noted in the issue for October 10, 1922 that a recent survey made by two inspectors of the Division of Sanitation shows that we have 885 premises depending upon private water supplies, most of them located in the outlying portion of the 72 square miles of territory comprising the city. No semi-public drinking supplies were found . . . Just another example of the mundane yet necessary routine of the Department in keeping the city safe.

Tax Levies for Public Health

But of course this costs money, and in the issue for November 10, 1922 we note a "plea for the extra tax levy . . ." And under this caption, the average per capita cost for health protection in our metropolitan cities today is 75 cents. Last year (1921) the City of Cincinnati appropriated \$162,576.50—40¢ per individual—in response to our budgetary request for \$192,000. This year we shall have approximately \$155,000—a very meager sum indeed for the health protection of 405,000 people . . . and so on and then:

Each dollar spent by the health department for the reduction of human waste has resulted in making Cincinnati a healthier city. To continue and do more we must have the financial assistance of our people. We must all remember that public health is purchaseable." Within certain limitations a community can determine its own death rate . . .

And the plea worked, for in the issue for July 10, 1925 we note that \$20,000 of an increase was awarded to the Health Department. (Funds must have really been tight within the previous three years because publication of the SANITARY BULLETIN had been suspended altogether.)

The issue for August 1, 1925, under the title "Looking Back Two Years" (1923-24), the situation during those years is discussed. It is noted that the appropriations for the two years were \$134,000 and \$138,000 respectively—or at the rate of 33¢ and 34¢ per capita. Very meager sums for the health protection of 407,835 people living within the corporate limits . . .

Negro Health

There is further discussion of the Negro—his health and race relations—in the issue for October 14, 1925:

Over one half of Cincinnati's Negro population lives in four downtown contiguous wards under conditions which

make the Negro the victim of causes which lower resistance to disease. Among the most important may be mentioned bad housing, ignorance, race prejudice, lack of opportunity and dissipation. We list bad housing first because it is the chief predisposing factor . . .

[Surely not an unfamiliar topic even today.] And, continuing,

under the Sheppard-Towner Act, approximately \$82,000 was appropriated by Congress and the General Assembly of Ohio for the protection of infancy and maternity in our state. In connection with the Sheppard-Towner work among colored people, the Department of Health, under the auspices of the pediatric department of the College of Medicine, the Cincinnati General Hospital, and the State Department of Health sponsored a course of lectures on pediatrics for colored doctors and a clinic week as our contribution to the national observance of Negro Health Week in 1924 . . .

Crippled Children

And for, and behalf of, crippled children we note that "under sections of the Ohio law provision is made for the treatment of indigent crippled children."

Winslow Speaks

At the annual meeting of the Public Health Federation on December 7, 1929, Dr. C. E. A. Winslow of Yale University was the speaker of the day, speaking on the subject "Public Health Today and Tomorrow."

The Deaf Child

In 1928 a program "on our education" for deafened children, using a "4-A audiometer" for testing was started by the Board of Education. As many as 40 children could be tested at one time.

Mortality

The problem of resident versus nonresident deaths is discussed in the issue for November 15, 1929. The CINCINNATI SANITARY BULLETIN gradually ceased to exist however. The department's publication is now CINCINNATI'S HEALTH and this is the second volume in its third issue. Cincinnati, having towns within its own periphery (eg., Norwood) had and still has a peculiarly good chance of being charged with deaths that do not properly belong. Thus Dr. Peters wrote:

The city of Norwood, actually surrounded by Cincinnati, enjoyed a low death rate but when figures are given out, they do not take into account the residents of Norwood who die in Cincinnati hospitals . . .

Swimming Pools

Life in a modern industrialized society is beginning to influence the development of programs in the Health Department. As an example we find a lengthy discussion of "swimming pool sanitation" in the issue for December 15, 1929. This article is penned by J. S. Huey, Chief Sanitary Inspector in the Department.

(Continued in February Issue)



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No. 1

Office Evaluation of Stature (Height) In Adolescence

EARL E. SMITH, M.D., and RALPH I. FRIED, M.D.

STATURE (height) ranks high as a concern of the teenager. In our conforming society the child who is considered "too tall" or "too short" may be exposed by the anxiety of his family to medical and even surgical procedures that might not be approved by more reflective medical opinion. Concern about stature as well as delayed or early maturation may lead to serious anxiety reactions with psychological inferiority feelings. These may be so severe that the adolescent may cease to function properly.

Since growth during adolescence is exceeded in rate only by the growth that occurs during the first year of life, it is quite natural that attention will be focused on stature during this period of life. The concern of the family and the patient may be allayed if the physician will take a few simple steps toward the accurate diagnosis and treatment of growth. In most instances it is not necessary to resort to complicated laboratory studies and x-rays to determine the status of the presenting patient.

One of the most helpful aids is a long growth history of the child, especially if it is kept on one of the several good growth charts available, such as the Wetzell Grid or the Harvard or Iowa charts. A review of the growth record of the child with reference to the past medical history and careful attention to the Maturation-Ratings as described in several papers is illuminating.¹⁻³ A good family

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history pertaining to growth is of great importance. A thorough physical examination of the patient including a urine examination as well as a measurement of the upper and lower body segments is essential. A history of intrauterine dwarfism with low birth weight should suggest a cautious prognosis as to eventual height as the individual may always remain small. In a very small number of cases there may be need for x-rays of the wrist for comparison with the Greulich-Pyle Standards⁴ which will give much information. On occasions other laboratory tests such as hormonal assays may be indicated.

The information gleaned from these procedures plus the perspicacity of the pediatrician on the nature of growth should enable him to render the family an accurate account of the current and future facts. In a recent publication⁵ in which we studied the postmenarcheal growth patterns of 600 girls, we demonstrated that most girls will grow 4 inches or less following the first menstrual period, a fact that

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we have utilized in reassuring girls who are concerned about being too tall.

The following case report concerns an entire family and especially the desire of the males to avoid being "too short." Short stature in males is most often constitutional or delayed adolescence or a combination of the two. This family illustrated the importance of good growth follow-up with good conservative advice to the family.

Case Report

The father of this family was 64 inches tall and the mother only 58 inches and their concern was further accentuated by the fact that the mother had been advised by an endocrinologist that had she been treated in childhood she would have grown taller. The records on this family were kept by one of us (E.S.) over a period of 18 years and were recorded on the Wetzel Grid. It is of great interest to note that over the life span of each child he or she maintained fairly closely his original channel and remained somewhat faithful to his original auxodrome which was immediate and good evidence to the pediatrician that these children had no organic aberrations and were probably proceeding as ordained by their genetic expectancy (Fig. 1). An extrapolation of their original auxodromes would have given an accurate prediction of eventual height at almost any time of their lives.

The height of the children was carefully followed from birth. In 1953 K.M. (6 $\frac{2}{3}$ yrs.) and R.M. (5 $\frac{3}{4}$ yrs.) were seen by Dr. Nathan Talbot of Harvard Medical School. He concluded that these children were probably normal although remarkably short for their age. At his suggestion a short trial of empirical thyroid therapy was initiated with no demonstrable effect.

In 1961 R.M. was seen by Dr. Samuel Spector of Western Reserve University for possible use of the Growth Stimulating Hormone of the pituitary. At this examination he was 12 $\frac{1}{2}$ years old and 51 $\frac{1}{4}$ inches tall. The physical and neurological examinations were entirely normal. There was no laboratory evidence to suggest hypopituitarism. His height age was 8 $\frac{1}{2}$ years and bone age 9 years. Dr. Spector concluded that this child was following the pattern of delayed adolescence, and in a constitutionally short child he suggested only observation.

The family history of height in this family is of both great interest and significance. (Tables 1 and 2.)

In summary, one can say that these four children of this interesting family represent an example of small stature in perfectly normal children whose size is being determined

genetically and complicated by delayed adolescence in two children. It would seem that there is nothing in our present armamentarium that would alter favorably the height of these children.

Discussion

Height is an important concern of the teenager visiting his pediatrician. Girls are worried about being too tall and boys about being too short. Therefore, it is important that the pediatrician be equipped with a *modus operandi* whereby he can make some reasonably accurate observation and predictions that will satisfy the patient and his family and protect the patient from useless and often dangerous hormone therapy and even from surgical procedures such as epiphysiolyis.

It is helpful if the pediatrician has a long growth record of the child. If he does not have this on his own records it can frequently be obtained from school records. These old and forgotten data can be revitalized and given new meaning when plotted on one of the standard growth charts. A good family history is the next important step in the diagnosis of height and stature. Obtaining the height and weight of the father, the age at onset of puberty and whether he was a late or early grower, is most important. The mother's height and weight, the age of onset of puberty and menarche and whether she was a late or early grower, is helpful. Similar data concerning other siblings as well as other distant members of the family are of value.

A good physical examination with special attention to application of Maturity-Ratings by Gallagher⁶ in the case of boys: in the girls, observation of the amount, type, and distribution of pubic hair, pigmentation of the genitalia and areola of the breasts, assessment of the muscular and skeletal development and the imminence of the menarche is essential. Most organic diseases can thus be ruled out. In addition an upper and lower ratio should be obtained. The lower segment is measured from the top of the sym-

TABLE 1. Height Status of Ancestors

Father 64".....	grandfather 58"	great-grandfather 63"	
	grandmother 62".....		great-grandmother 65"
Mother 58".....	grandfather 61"	great-grandfather 73"	
	grandmother 66".....		great-grandmother 58"

TABLE 2. Present Status of the Children — 1965

AGE				HEIGHT	MATURITY-RATING	Predicted Ht. WETZEL GRID
K.M.	(m)	18-1/12	12/64	63"	V	63"
R.M.	(m)	17	9/65	62"	V —	63-1/2"
D.M.	(m)	13-2/3	5/65	56"	III	64"
P.M.	(f)	10-2/3	6/65	50"	II	59-1/2"

Name: MEYER, KENNETH

GRID for Evaluating PHYSICAL FITNESS in Terms of PHYSIQUE (Body Build), DEVELOPMENTAL LEVEL, and BASAL METABOLISM — A Guide to Individual Progress from Infancy to Maturity —

No.

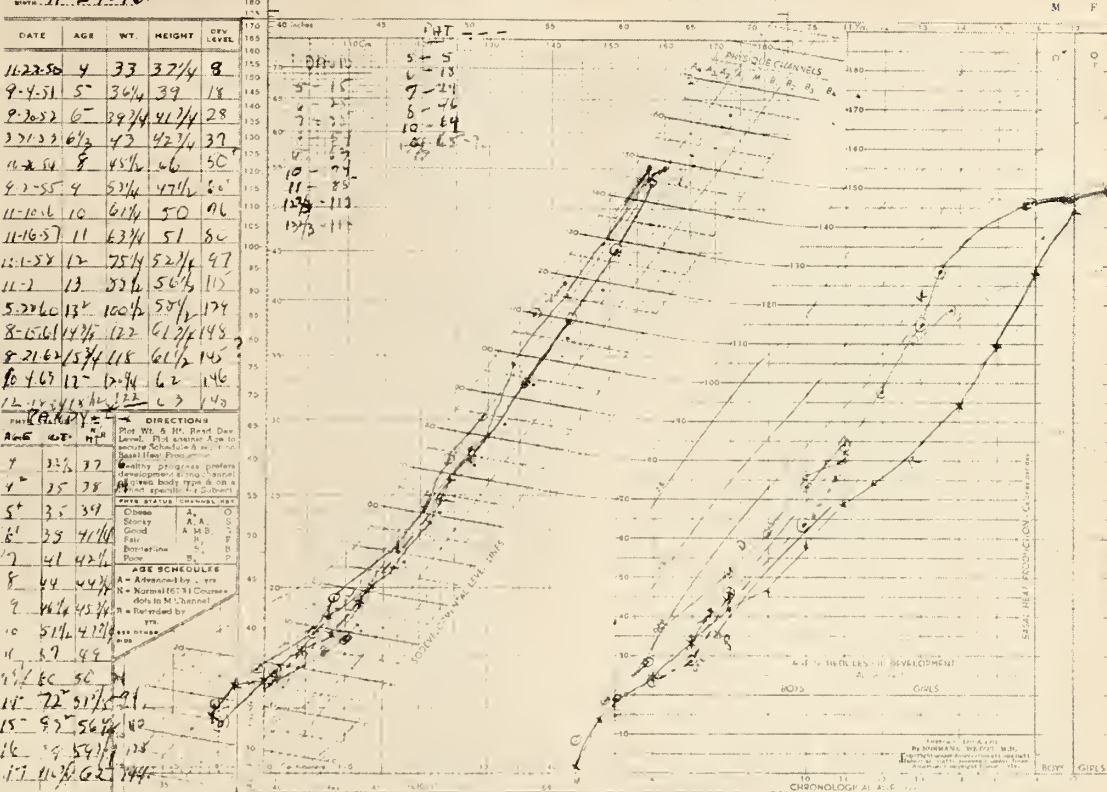
DATE OF BIRTH: 11-22-46

FIG. 1. Growth Records of Four Siblings, Utilizing the Wetzel Grid.

physis pubis to the floor. The upper segment is derived by subtracting the lower segment from the total height. (Ratio—upper segment/lower segment) At birth the ratio is approximately 1.7/1. The legs grow more rapidly than the trunk so that by the age of 10 or 11 years the segments are approximately 1/1. Tables showing normal ratios should be consulted. Hypothyroidism gives an infantile upper to lower ratio (high upper). Chondrodystrophy or abnormalities of the long bones give an abnormal ratio. In all other conditions the ratio is normal.

West and Smith⁸ in an attempt to elucidate the cause of growth retardation in renal disease demonstrated that in every case, reduction of urinary concentrating ability occurred. This also was observed in a few patients growing normally. On the other hand chronic acidosis was present in only 76 per cent of the stunted patients but was never observed in children growing normally. In the majority of cases, concentrating ability can be fairly accurately judged by the specific gravity of several routine morning urine specimens without resorting to special preparation of the patient for a concentration test. In cases in which routine specimens show low values, a simple concentration test, such as that described by Fishberg⁹ may be done. With specimens of small

volume, the falling drop method for urinary specific gravity*, requiring only a fraction of a cubic centimeter of urine, has been found equal in value to the hydrometer method.¹⁰

Approximately 98 per cent of cases relating to growth problems are physiological and fall into the category of genetically determined height, delayed adolescence, or both. A prognosis can thus be made by the physician in his office without recourse to expensive complicated laboratory procedures. In the few cases which do not fit into this category, laboratory aids, such as determination of bone age by x-ray¹¹ and thyroid function, are important aids in a more perfect diagnosis. In difficult cases more complicated laboratory procedures such as hormonal assays may be initiated. The grid or growth chart serves as a good graphic representation of any deviation from the normal flow of growth.

Kaplan¹² recently discussed the case of growth hormone in the treatment of short stature. He points out that many children whose growth retardation begins in the early preschool years or later, do not mature until they are in their middle or late teenage years. After such late maturation, however,

*The specific gravity in one drop of urine can be measured with a TS Meter, available from the American Optical Company, Buffalo, New York.

these children reach normal heights in the majority of instances. It is difficult to believe that growth hormone deficiency exists in these individuals because ultimately normal stature is reached. In the Johns Hopkins Hospital Clinic, of 442 cases of dwarfism only 6 or 1.4 per cent could be properly classified as hypopituitary dwarfs.

At present, with the supply of growth hormone so limited, the cost so great, and the effects inconclusive, use should be limited to research situations. The use of other agents such as androgens or their analogues may speed up growth but lead to earlier closure of epiphyses and possibly eventual decreased height. Some of these agents give rise to side effects which may be more harmful than the questionable gain. Such agents should be used only for the late adolescence where psychologically it is essential to speed up maturation.

Soyka¹³ observed clinically significant increases in growth rate in 11 of 13 hypopituitary patients. No significant improvement in linear growth rate was noted in children whose short stature was due to other conditions. Noted also was that the thyroid hormone exhibits only a supportive and permissive action on growth and is therefore useful only in primary hypothyroidism. It has been demonstrated that thyroid alone has no beneficial effect on linear growth of short euthyroid children or of hypopituitary dwarfs.

As for the too tall girl, great care must be utilized before one embarks on a program of hormonal therapy. Discussion of this phase is not within the province of this paper, but the reader is referred to a number of articles written on this subject.^{14,15}

Finally, all of this evidence must be weighed and evaluated by the pediatrician in the light of his own general experience with the phenomenon of growth, and his knowledge of the patient he is counselling at the moment.

Summary

A review of height as an important concern of teenagers, both male and female, is presented. An interesting family case history illustrating the con-

cern of the family and their anxiety for positive action is recorded. Suggestions are made for the physician to follow in order to make a diagnosis and prescribe necessary treatment. Most problems relating to stature are due to delayed adolescence and genetic factors. Thus, the most important therapeutic role of the pediatrician is to allay anxieties and prevent useless and even harmful procedures from being used.

Conclusion

Masterful inactivity therapeutically, but much activity as far as education and reassurance, is recommended.

Acknowledgment: We wish to acknowledge the suggestions and criticisms by Dr. Samuel Spector, Professor of Pediatrics, Western Reserve University School of Medicine.

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PUT THESE DATES ON YOUR CALENDAR: May 16-19, for scientific and clinical features of the 1967 Annual Meeting of the Ohio State Medical Association in Columbus. Join your colleagues at Ohio's No. 1 postgraduate program of the year. Watch for complete details in the April issue.

Metabolic Screening

DERRICK LONSDALE, M. D.

WITH the advent of compulsory screening for phenylketonuria in the newborn in the State of Ohio, it is perhaps salutary to consider what gains can be expected and to what this routine procedure will lead. First, it is important to realize what information is yielded by the screening test that is in use, for, although the test may be used with reasonable accuracy to monitor phenylalanine content in the blood, once the diagnosis has been made, it does not of itself initiate the diagnosis of phenylketonuria. Elevation of phenylalanine blood levels in the newborn is a relatively common finding; the disease that has received the name *phenylketonuria* is rare. To prescribe for a baby the necessary artificial diet without making a definite and unequivocal diagnosis is fraught with risk, and may do irreparable damage to the infant's developing brain. The slow mental development that thus may occur may then be attributed to the mistakenly diagnosed phenylketonuria, whereas it is in reality simply dietary deprivation of the essential amino acid phenylalanine.

Guthrie-Susi Test

The screening test of Guthrie and Susi¹ depends on a relatively simple principle. By the addition of a phenylalanine antagonist to a bacterial culture medium, the metabolism of this essential amino acid by *Bacillus subtilis* is inhibited and the bacillus is unable to grow. If a small amount of blood with an increased phenylalanine content is then added to the culture medium the action of the antagonist is overcome and the bacillus will grow and form a colony. The size of the colony is roughly proportional to the amount of phenylalanine present in the tested blood, and a calibration is thereby possible. The report of an increase in the content of phenylalanine in the blood is sent out from the State Laboratory to the responsible physician, but it in no way implies a *diagnosis* of phenylketonuria. Negative tests are not reported.

It is essential then to check the blood content by more accurate chemical means. It is also necessary to find evidence in the urine and in the blood of the ketones from which the disease gets its name. The

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ferric chloride test will not show the characteristic color change in the urine until the blood content of phenylalanine is in the range of 15 to 20 mg. per 100 ml. This test also depends on the presence of the keto acids, which develop as a result of the inherent metabolic error, and does not depend solely on the content of phenylalanine in the blood. A screening test is aimed at detection of increased content of phenylalanine before the urine shows evidence of the abnormal ketones, when a significant amount of brain damage already may have occurred. Another difficulty that arises is the fact that it may be as long as six weeks before a phenylketonuric child will have a significant increase in phenylalanine content in the blood, and it is for this reason that a second screening test is performed when the infant is between three and six weeks of age.

It is not generally recognized that the symptoms of phenylketonuria, or indeed any of the group of inborn errors of metabolism, in which brain damage is involved, may be quite unalarming and nonspecific. These symptoms may be irritability, vomiting, eczema, and seizures,² and every physician commonly sees many babies with the first three symptoms. A number of babies with phenylketonuria, for example, have been subjected to laparotomy under the impression that they were suffering from pyloric stenosis. Unfortunately, the rarity of these inborn metabolic errors make it easy indeed to neglect such symptoms until it is too late. Seizures in the newborn are rare, and the earlier such seizures commence in life, the more likely it is that they have a metabolic cause.

Positive Results

What should a physician do when he receives a report of an elevated phenylalanine level in the blood from a screening test? It is mandatory that he refer the infant to a medical center where the necessary

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metabolic diagnostic studies can be performed. It is imperative at this stage that a correct diagnosis be made, as the normal level of phenylalanine thereafter may be interpreted as reflecting good control from the diet. Once the diagnosis has been confirmed by means of chromatographic analysis of the blood and urine it is a relatively easy thing to manage the problem at home if periodic blood evaluations can be arranged.

In regard to the many problems involving the dietary control, there is an excellent nursing advisory service provided by the Ohio State Department of Health, from which the family may be able to draw assistance. From the physician's point of view, control may be made more difficult by the fact that a high blood level of phenylalanine will arise from too little phenylalanine in the diet as well as too much. If the child is receiving too little, he will digest his own tissues and may even form keto acids endogenously. Under these circumstances there will be a slowing or cessation of the physical growth and development. We, like others, have found that a phenylalanine content of between 5 and 10 mg. per 100 ml. of blood is probably in the optimum range.

What, then, is the cause for positive Guthrie-Susi tests, other than phenylketonuria? Some premature infants are known to have high phenylalanine levels in the blood for a variable period. This phase is accompanied by elevation of tyrosine levels as compared with low tyrosine levels in infants with phenylketonuria. A number of healthy full-term infants have elevated levels of both phenylalanine and of tyrosine, correctable by the administration of ascorbic acid, which appears to be a coenzyme in the metabolic pathway. To date, all the falsely positive tests have related to elevation of phenylalanine content in the blood from reasons other than phenylketonuria. There have been no reports of the disease having escaped detection through failure of the test.

Scheel and Berry³ reported a high incidence of false-positive results, with as many as 21 per cent showing values of more than 8 mg. of phenylalanine per 100 ml. of blood. These results were obtained, however, in a series of only 95 newborn infants. This has not been substantiated by other workers, and Guthrie and Susi¹ reported that from tests on 682 infants, none exceeded 4 mg. per 100 ml. and only 8 per cent were more than 2 mg. per 100 ml. The Academy of Pediatrics recommended in 1965 that the test should be used on all infants, no sooner than 24 hours after commencement of milk feeding and before discharge from the hospital.

The Academy made a recommendation, at the same time, that all newborn infants should be screened for the presence of reducing substances in the urine. The test should not be the glucose oxidase tape test as that is specific for glucose and will not detect galac-

tose, fructose, or sucrose, all of which may appear in the urine in cases of hereditary melituria. Efron and associates⁴ have suggested a chromatographic screening method for detection of the numerous other diseases of this nature, but this is a specialized technic and is not readily available where chromatography is not a standard laboratory procedure. It is doubtful that its cost would warrant general use at the present time, although it could be performed, like the Guthrie-Susi test, in a central laboratory.

Carson and Neill⁵ reported screening tests on specimens of urine from 2,081 mentally retarded individuals in Northern Ireland, and discovered 49 cases of phenylketonuria, together with a few other metabolic errors. This does not, however, indicate the incidence in the general population. Efron⁶ reported the true incidence of phenylketonuria in the Commonwealth of Massachusetts as 1 in 10,000, according to a screening program. This was stated to be twice the expected incidence on the basis of institutionalized retarded patients. The concentration of cases in the State of Ohio has not yet been determined, but several cases of phenylketonuria have been discovered by means of the state screening program.

Cost

The cost of any such program and its yield of positive results has to be weighed against the cost of a lifetime of institutional care, but in terms of human misery and suffering, there is no comparison. Anyone who has had the satisfaction of observing progress in a child treated for phenylketonuria recognizes the benefit that can be obtained from correct and diligent therapy. The understanding of the many causes of mental retardation is in its infancy, and our knowledge of brain chemistry can only be increased from the study of these rare diseases. Many physicians believe that such patients are unlikely to come within range of their practice, because of the rarity of the disease, but a suspicion may lead to further diagnostic study that would contribute some important information to our increasing understanding of brain metabolism.

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Sclerema Neonatorum

A Report of Nine Cases

GUILLERMO VILLACORTE, M.D., and DONALD J. FRANK, M.D.

USEMBENZIUS is credited with the first description of this disorder in 1718.¹ Underwood included it for the first time in his book, *Treatise on Diseases of Children*, in 1784.² Thereafter the condition became known as Underwood disease until Causier introduced the term "sclerema" (a Greek derivative meaning hard) in the French literature in 1812. Since that time infrequent case reports and explanations as to etiology as well as the rationale for treatment have appeared in the literature.^{3,4}

Sclerema neonatorum is now considered by most authorities to be a nonspecific morbid sign occurring uncommonly in the first few weeks of life during the course of a potentially fatal illness. It is characterized by the presence of a diffuse, rapidly spreading, nonedematous, brawny induration of the skin and subcutaneous tissue. The process usually begins at the buttocks or thighs and may spread to any part of the body with the exception of the fat-free palms, soles and scrotum.⁵ Survival or death is more often related to the associated primary disease than to the extent and severity of sclerema.⁶ The exact etiology and pathogenesis of sclerema neonatorum are still unknown.

Histologically, this condition is characterized by a picture similar to subcutaneous fat necrosis, although to a lesser degree. There is a shrinking or necrosis of the adipose tissue and thickening of the trabeculae. Masses of fibroblasts arise from the latter and invade the fat lobules, where giant cells, lymphocytes, leukocytes and fat crystals may also be found. Chemical analysis of the subcutaneous tissues of both sclerematous and non-sclerematous infants reveals no significant difference between the two groups.⁷

Sclerema neonatorum in the past has been confused with subcutaneous fat necrosis and scleredema. Subcutaneous fat necrosis is thought to be secondary to obstetric trauma and is characterized by self-limited, localized, well demarcated induration of the subcutaneous tissue. The indurated areas are most commonly found over bony prominences. It occurs

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in otherwise healthy newborns. Scleredema, on the other hand, is usually generalized, firm, pitting edema occurring primarily in sick premature infants, although occasionally it may also be found in debilitated full-term newborns.⁸

The purpose of this report is to review and analyze our clinical experience with sclerema neonatorum during a two and one-half year period. There were 14,174 live-born infants delivered at the Good Samaritan Hospital during the study. Six per cent or 896 of the total infants in the study were premature by weight and gestation. Only nine or 0.063 per cent developed sclerema neonatorum. All nine infants were premature by weight, six of the nine were premature by weight and gestation. The average birth weight was 1921 Gm. The range was from 1219 to 2424 Gm. The average length of gestation was 34.6 weeks, with a range of 27 to 42 weeks.

The following additional information was accumulated:

Maternal Age and Parity. The average maternal age was 27.8 years, and the range was from 19 to 33 years. All but two of the nine mothers were multiparas.

Complications of Pregnancy, Labor and Delivery. Four mothers had complications, e.g., asthmatic bronchitis, abruptio placenta and premature rupture of membranes. Labor was uneventful in all cases. One delivery was complicated by three twists of the cord around the baby's neck.

Type of Delivery. All nine babies were delivered vaginally. Six were spontaneous, two were breech,

From the Department of Pediatrics of the Good Samaritan Hospital, Cincinnati, Ohio. Submitted May 17, 1966.

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and one was delivered by elective low-forceps extraction.

Type of Anesthesia. Spinal anesthesia was used in four deliveries and general anesthesia was used in another four. One baby was delivered without anesthesia.

Apgar Score. The Apgar scores taken one minute after birth ranged from 1 to 10, with an average of 6.7.

Sex. Of the nine cases of sclerema neonatorum, six were males and three were females.

Age of Onset. The average age of onset of sclerema neonatorum was 27.2 hours, with extremes ranging from 8 to 48 hours.

Extent. The process was extensive in six of the nine cases, including the two survivors.

Duration. The average duration (from the time of onset of sclerema to the time of its disappearance) was 84 hours, and the range was from 72 to 96 hours. The average age at the time of death was 56 hours, with a range of 23 to 96 hours.

Mortality. Seven of the nine infants died. The uncorrected mortality was 77.7 per cent.

Primary Illness and Other Complications. All nine babies developed mild to moderate respiratory dis-

tress at, or shortly after birth. Five babies exhibited obvious hyperbilirubinemia. No group incompatibility or cause other than hepatic immaturity could be established etiologically to explain the jaundice. Two had jaundice within 24 hours and the other three developed jaundice during the course of the primary illness. At autopsy, one baby was found to have a hypoplastic left heart.

Body Temperature of Infants. Borderline or obvious hypothermia was not encountered in any of the nine infants studied.

Autopsy Findings. Six of the seven infants that died came to autopsy. Four infants had extensive pulmonary hyaline membrane disease. One had lobar emphysema and hydrothorax, and the other, as previously mentioned, had a hypoplastic left ventricle and evidence of severe cardiac failure.

Treatment. The two surviving infants were treated with steroids and antibiotics. One of these infants received intravenous fluids, while the other one was exchanged because of hyperbilirubinemia (Table 1).

Of the seven infants that died, three received both steroids and antibiotics; one infant was given steroids but no antibiotics, whereas two infants were treated

TABLE 1. *Sclerema Patients — Recovered*

Birth Weight (Gms.)	Age at Gestation (Wks.)	Race and Sex	Apgar Score	Complications of Pregnancy	Age at Onset (Hrs.)	Duration (Hrs.)	Primary Illness	Treatment
1758	31	W/M	4	None	24	72	Mild RDS* Atelectasis Hyperbilirubinemia	Steroid Antibiotics Exchange transfusion
1800	34	W/F	9	Twins	40	96	Moderate RDS Atelectasis Hyperbilirubinemia	Steroid Antibiotics I. V. Fluids

*Respiratory Distress Syndrome

TABLE 2. *Sclerema Patients — Died*

Birth Weight (Gms.)	Age at Gestation (Wks.)	Race and Sex	Apgar Score	Complications of Pregnancy	Age at Onset (Hrs.)	Age at Time of Death (Hrs.)	Autopsy Findings	Treatment
1559	36	W/F	7	Twins	31	78	HMD***	Steroid Adrenalin I. V. Fluids
1676	27	W/M	7	None	8	23	No Autopsy Moderate RDS*	None
2424	42	W/M	1	Cord around the neck x 3	10	28	Emphysema Hydrothorax	Steroid Antibiotics Prenzyne****
2268	37	W/M	10	PRM**	24	48	HMD***	Steroid Antibiotics
2268	35(?)	W/M	8	PRM** Asthmatic Bronchitis	24	50	HMD***	Steroid Antibiotics
2325	40	W/F	9	None	36	64	Hypoplastic Left Heart Syndrome	Antibiotics
1219	30	W/M	6	PRM** Abruptio Placenta	48	96	Atelectasis HMD***	Antibiotics

*Respiratory Distress Syndrome

**Premature Rupture of Membrane

***Hyaline Membrane Disease

****Trypsin

with antibiotics without steroids. One infant received no treatment (Table 2).

Comment

Hughes and Hammond,⁹ in their excellent review of the subject, found that only a minority of infants with sclerema were premature. This is in marked contrast to the results of this study, in which all infants were premature by weight, and six of nine were premature by weight and gestation.

Sclerema neonatorum is a rather uncommon pathologic entity. As physicians become more aggressive in their approach to the diagnosis and treatment of distressed newborns, a further decrease in incidence may be anticipated.

The etiology and pathogenesis of this condition remain obscure.¹⁰ This review and others have demonstrated that sclerema acts as a "fellow traveler" in infants seriously ill as a result of other specific disease entities.

Although the variety of primary diseases with which sclerema may be associated is legion, seven of the nine infants reported here were noted to have moderate to severe respiratory distress. Four of the six infants that came to autopsy had pathologic evidence of hyaline membrane disease. Perinatal factors, age at onset, duration and the extent of spread do not appear to alter prognosis.

In the past, many means of therapy have been tried including steroids and antibiotics. We concur in the conclusions of Levin,¹¹ Leider¹⁰ and Warwick⁷ that

neither of these therapeutic maneuvers appear to be effective in reversing the process.

Conclusion

Sclerema neonatorum is a rare entity. When it does occur, it should be regarded as a grave prognostic sign of an accompanying disease process.

Prompt and proper management of the primary illness appear to be far more important in the prognosis than attempts to "melt the tallow."

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THE MEDICAL PRACTITIONER, ALCOHOLISM AND MOTIVATION. — Adverse influences on motivation for recovery from alcoholism must be searched for in three areas: society, the medical practitioner and the patient. Society is ambivalent because there is a vicarious release through identification with the cheerful "drunk" coupled with unconscious envy and resentment leading to punitive action.

The current "alcohol culture" decrees that to drink is to be well, not to drink is to be ill.

The medical profession attempts to suppress, deny, rationalize or reject the problem of alcoholism because it involves a change in attitude and recognition of limitations.

The alcoholic patient has a notorious lack of motivation, but this must be recognized as a symptom of his disease, and with certain techniques this symptom is treatable. Furthermore, motivation fluctuates and many opportunities for treatment are available when the medical practitioner can detect that motivation is high. At times a coercive approach is required, at times a permissive one; and the optimal use of such approaches will increase the motivation to an effective level. — Max Hayman, M.D., Los Angeles: *California Medicine*, 104:345-351, May 1966.

The International Conference On Tetanus

Bern, Switzerland, July 1966

WESLEY FURSTE, M.D.

THE SECOND International Conference on Tetanus was held at the Tiefenauhospital der Stadt Bern in Bern, Switzerland, July 15 through July 19, 1966. It was sponsored by the Swiss Academy of Medical Sciences with the support of the World Health Organization. The first Conference was held in India in 1963, and the third is planned for an undetermined country in 1969.

Representatives of countries of all parts of the world, such as the United States of America, the United States of Soviet Russia, Brazil, Bulgaria, and Japan, were present. The 65 invited participants were from both the preclinical and clinical disciplines. Among the scientists and clinicians present were Dr. C. I. Masar (epidemiologist from Czechoslovakia), Professor S. D. Rubbo (bacteriologist from Australia), Professor W. E. van Heyningen (biochemist from England), Dr. Geoffrey Edsall (immunologist from the United States), Dr. P. M. Smythe (pediatrician from South Africa), and Dr. J. C. Patel (internist from India). The conference chairman was Dr. Leo Eckmann, who has published in German and English a book entitled "Tetanus Prophylaxis and Therapy."

The official language was English, but participants discussed papers in English, French, German, and Russian.

The purpose of this report is to summarize some of the ideas which were expressed at the Conference and which are of interest to clinicians. No attempt will be made to cover all aspects of the Conference nor to give references which will be available in the complete published "Proceedings."

Epidemiology

Tetanus continues to be an ever present threat in these days of numerous automobile collisions, burns, occasional airplane crashes, and other accidents. It can occur as a complication of lacerations, compound fractures, burns, abrasions, hypodermic injections, of operations on the gastrointestinal tract, and

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of birth (infection of the umbilical stump in the newborn). Independent reports from the United States, Czechoslovakia, and Sweden indicated that the portal of entry of *Clostridium tetani* could not be found in about 14 per cent of non-neonatal cases of tetanus.

Tetanus is much more prevalent in the warmer areas of the world than in the cooler areas.

As would be expected, tetanus has a much greater incidence in developing countries than in the developed nations. In the developing countries where tetanus toxoid immunization has not been accomplished in pregnant women and where midwives assist at deliveries, neonatal tetanus is particularly prevalent, and has a mortality rate as high as 95 per cent. In one such country, a blind midwife had a record of eight cases of neonatal tetanus in 30 deliveries!

In the developing countries, probably more than 1,000,000 cases of tetanus occurred in the 1950-1960 decade. In the United States of America, in contrast, only 58 cases for the entire nation were reported during the first 23 weeks of 1966 to the Public Health Communicable Disease Center.

Immunology and Prophylaxis

The ideas reported here are taken from "Guide Lines for the Medical Profession Regarding the Prevention of Tetanus." These "Guide Lines" were prepared during special sessions at which they were discussed in great detail. Although they obviously could not please every invited participant, they were voted on favorably at the end of the Conference as

a generally conservative expression of the participants.

The basic concepts in any tetanus prophylaxis program involve (1) tetanus toxoid, (2) tetanus antitoxin, (3) surgical care of wounds, and (4) emergency medical identification devices.

Tetanus Toxoid

Whereas prophylactic measures rendered at the time of injury to nonimmunized patients cannot be guaranteed to offer protection, prior active immunization with a booster dose of tetanus toxoid at the time of injury offers effective and prolonged protection.

During World War II, fluid tetanus toxoid made possible a previously unparalleled record for United States of America Army injured personnel when, during the course of 2,734,819 hospital admissions for wounds and injuries, only four cases of tetanus occurred in completely actively immunized individuals. In spite of such a record and because it has been possible to produce active immunization with purer and more effective adsorbed toxoids, there has been an increasing enthusiasm for adsorbed toxoids. At first, there was in the literature evidence that only fluid toxoid could be used for simultaneous active-passive immunization, but, within the past year, there have appeared reports to show a more effective, simultaneous, active-passive immunization is produced with adsorbed toxoid.

Other general aspects of the toxoid problem were discussed. Concern was expressed that unfortunately all toxoids do not contain the same number of Lf units per milliliter and should be standardized. A single injection toxoid which would require only a booster dose at the time of injury is being studied in Brazil. For years and at the present time, a 50 per cent fluid and 50 per cent adsorbed toxoid mixture which contains 15 Lf per ml. is distributed in Sweden as the standard toxoid. Rapid active immunization, i.e., three doses over a period of about a week, was evaluated, and was not supported by the conference participants.

For initial active immunization, for infants and children, three intramuscular injections of adsorbed toxoid in combination with other antigens after the third month of life were recommended, and, for adults, three intramuscular injections were also recommended. The first and second injections are to be given about four to six weeks apart, and the third, 6 to 12 months later. By active immunization of the mother before or during the first six months of pregnancy with two intramuscular injections of adsorbed toxoid, neonatal tetanus is preventable.

The period of time after which a routine booster should be given was the subject of much discussion in view of the efficiency of the more recently developed toxoids and in view of the very minimal but

definitely increasing frequency and severity of toxoid reactions. At one extreme was the opinion that boosters should be given every six to ten years; at the other extreme was the feeling that — if a patient once had the basic immunization — he need not get a booster dose until the time of injury.

Likewise, the wound booster interval was the subject of much debate. Some participants believed that — with adequate, prior, active, immunization — a wound booster need not be given until two, three, or even four years had occurred between the time of a routine dose and the time of an injury. Nevertheless, the final statement in the "Guide Lines" was that, when a completely vaccinated patient is injured, he should receive a toxoid booster unless he has had one during the previous year. In view of a reported case of tetanus following a superficial injury in a United States of America Marine veteran with only a 10 month interval since his last booster, and in view of other considerations, the author at the present time believes that the wound booster interval should not be longer than one year. In addition, individuals who suffer very severe or very deep wounds should probably have a booster even though the interval since the last toxoid injection is less than one year.

At the time of injury, unvaccinated or incompletely vaccinated patients should receive a dose of tetanus toxoid followed by completion of active immunization.

Homologous Antitoxin

Tetanus immune globulin (human), which is homologous serum, and which hereafter will be referred to as TIG(H), is to be used if seroprophylaxis is indicated. The recommended dose is 250 units. TIG(H) should be given deeply intramuscularly, and should not be given intravenously. According to a Canadian report, only 50 units of TIG(H) may be necessary, and such a small dose may potentiate the effect of toxoid given simultaneously. Twenty-four synonyms for TIG(H) have been found by the writer in the literature.

Heterologous Antitoxin

The use of equine antitoxin, which is heterologous serum, carries certain risks, and its efficiency is limited. To support the medicolegal position of physicians, the Conference participants went on record as stating that it is the final medicolegal right and prerogative of an attending physician to decide whether or not a heterologous serum with its associated dangers should be used. If TIG(H) is unavailable and if seroprophylaxis is indicated, the recommended dose of heterologous antitoxin is 1,500 to 3,000 units.

Surgical Wound Care

The importance of surgical and postsurgical technique in the prophylaxis of tetanus must be em-

phasized. Thorough cleansing and débridement of wounds — at times leaving wounds open — remain two of the most important features of prophylaxis against tetanus. Necrotic tissue and foreign bodies can be massively contaminated with the tetanus bacillus, and can serve as a nidus in which the lethal toxin can be produced. Hence, it is most important to remove such tissue and foreign bodies. If the wound is massive or old, an endeavor to convert an anaerobic environment to an aerobic environment by leaving the wound wide open and with drainage is proper, and indicated, therapy.

The importance of thorough débridement of wounds in prevention of tetanus was emphasized. Nevertheless, a disturbingly large number of cases of tetanus follow small and relatively superficial wounds, or even occur in individuals in whom a wound cannot be demonstrated. Gas bacillus infections, in contradistinction, occur almost exclusively in deep and extensively traumatized wounds. Since tetanus may occur with very minimal or non-demonstrable wounds, toxoid immunization remains the most practical prophylaxis against tetanus.

Identification Devices

In any program for tetanus prophylaxis of a large population, the problem of identifying those who have received adequate active immunization is of particular importance. Many adults do not know exactly what injections they have received, and mothers often have not been informed about what prophylactic injections their children have been given. Some hospital emergency departments give patients who have received tetanus toxoid a note to that effect. Individuals should have some type of personal medical identification device (metal tag, button, card, tattoo) which should be available in the event of an emergency.

If every individual carried some type of emergency medical identification device, history-taking upon injury could be greatly simplified and expedited, tetanus toxoid immunization could be accurately and scientifically performed, overdosage and unnecessary injections of tetanus toxoid could be avoided, and injections in the rare individual who is sensitive to tetanus toxoid could be eliminated.

Antibiotics

Antibiotics, such as penicillin, have been shown to be effective against vegetative tetanus bacilli both in vitro and in experimental animals. They have no effect against toxin. The effectiveness of antibiotics for prophylaxis remains unproved, and, if used, they should be given over a period of at least five days.

Therapy

Throughout the discussion on therapy, there was always present the concept that the evaluation of therapeutic agents and methods is quite difficult to accomplish. If methods of therapy are to be eval-

uated correctly, there should be developed a uniform system of grading of tetanus. If such a system is not developed, cases of mild tetanus with a low mortality rate may be wrongly compared with cases of severe tetanus with a high mortality rate.

In areas where tetanus is prevalent, tetanus centers or wards or teams can more effectively treat tetanus and evaluate methods of therapy than physicians in hospitals where only an occasional case of tetanus is treated.

Tracheostomy had enthusiastic support if it could be adequately cared for by hospital nurses, interns, and residents and if respirators were available when needed. The importance of enthusiastic and well trained nurses was particularly stressed. Many felt that an improperly cared for tracheostomy was worse than not having one.

Serotherapy and Antibiotics

Numerous ideas were expressed about serotherapy and antibiotics. The following conclusions of Patel of India, who has studied 4,718 cases of tetanus, appeared to be significant insofar as heterologous antitoxin is concerned:

- 1. In the treatment of tetanus, a dose higher than 60,000 units of antitoxin serum (A.T.S.) is harmful.
- 2. Any dose of A.T.S. between 5,000 and 60,000 units gives similar results.
- 3. A.T.S. in the dose of 1,500 units by itself gives results which are inferior to 20,000 units. Massive doses of penicillin along with 1,500 units of A.T.S., however, give results which are similar to those obtained with 20,000 units of A.T.S.
- 4. A.T.S. is necessary to neutralize the circulating toxin in the blood of patients of tetanus. Withholding A.T.S. with or without massive doses of penicillin gives results which are inferior to those obtained with 20,000 units.
- 5. The minimum dose of A.T.S. that could be given to a patient of tetanus is 1,500 units along with massive doses of penicillin. A dose of 20,000 units of A.T.S., however, is recommended in the treatment of tetanus as the amount which would take care of those cases which have received heterologous serum in the past.
- 6. In neonatal tetanus, there is no significant difference in the results with an A.T.S. dose of 1,500, 5,000, 10,000, or 20,000 units or even when no A.T.S. was given. A dose of 1,500 units, however, is recommended to neutralize the circulating toxin.

Probably one injection of only 1500 units of TIG(H) is indicated in serotherapy and possibly one injection of only 500 units is necessary. Homologous serum is certainly to be preferred to heterologous antitoxin, but, at the present time, few countries are as fortunate as the United States of America where the commercial producers have endeavored to meet the clinical demands for TIG(H).

Little enthusiasm was shown for hyperbaric oxygen therapy in view of the complications of such treatment. It was noted that possibly some of the tetanus cases which were supposed to have been cured by such therapy were actually not tetanus. Tetanus is a toxemic state and not due to bacteria which are spreading throughout the body and which might be acted upon by oxygen in the circulating blood. In India, investigators would like to have a trial use of hyperbaric oxygen chambers as a means of therapy for treating many patients at once.

Just as little enthusiasm was expressed for hyperbaric oxygen therapy, little support was given to hypothermia as a type of therapy. The point was made and supported by a number of those in attendance that tetanus per se does not cause fever but that the complications of tetanus cause fever. Hence, the complications should be treated, not the fever itself.

Numerous comments were made about different muscle relaxants. All agreed that relaxation is necessary, and should be carried out by the most effective means available for the therapist.

Tetanus toxoid should be given as a patient recovers from tetanus to prevent recurrent tetanus. Its administration will not interfere with continuing improvement.

A PLAN FOR TETANUS PROPHYLAXIS

After attending this Conference, and in view of problems peculiar to the United States of America, the author presents the following plan for tetanus prophylaxis:

Basic or Primary Immunization With Toxoid

This immunization consists of the initial series and the reinforcing injection which are administered in the following manner:

1. For the *initial series*, give intramuscularly two injections of 0.5 ml. of adsorbed toxoid at an interval of about one month.

2. For the *reinforcing injection*, six months to one year after the initial series, give intramuscularly 0.5 ml. of adsorbed toxoid.

Periodic Booster Immunization

Six to 10 years after the reinforcing injection or the last booster injection, give intramuscularly 0.5 ml. of adsorbed toxoid. If the patient has a history of an abnormal reaction to toxoid, consider giving 0.1 ml. of adsorbed toxoid, 0.1 ml. of fluid toxoid, or neither toxoid.

Regimes for Prophylaxis Against Tetanus For the Wounded

The following different regimes are planned for (1) the patient who has had previous, adequate, tetanus toxoid immunization and, (2) the patient who has not had such immunization:

1. If there has been previous, adequate, tetanus toxoid, immunization proceed as follows:

a. To the wounded individual who within six years of the time of injury has had either the basic immunization or a booster dose of tetanus toxoid, give intramuscularly 0.5 ml. of toxoid, carry out the indicated surgical care of the wound, and, for a severe, old wound, consider the use of penicillin or oxytetracycline.

(1) If, however, the character of the wound does not indicate an overwhelming possibility of tetanus infection and if the wounded individual has had the basic immunization or a booster dose during the previous year, do not give a booster dose.

b. To the wounded individual who has not had the basic immunization or a booster dose within six years of the time of injury, give intramuscularly 0.5 ml. of toxoid, and render proper surgical care of the wound.

(1) To such wounded individuals, however, if the character of the wound indicates an overwhelming possibility of tetanus infection, give intramuscularly in one upper extremity 0.5 ml. of toxoid, administer with a different syringe and a different needle deeply in the contralateral gluteal muscles 250 units of tetanus immune globulin (human), render the proper surgical care, and consider the use of penicillin or oxytetracycline.

2. If there has not been previous adequate tetanus toxoid immunization, treat as follows:

a. For the wounded individual with a clean minor wound for which passive immunization is not necessary, give intramuscularly 0.5 ml. of toxoid, and surgically care for the wound.

b. For the wounded individual with a moderately severe or severe old wound, give intramuscularly in one upper extremity 0.5 ml. of toxoid, administer with a different syringe and a different needle in the contralateral gluteal muscles 250 units of tetanus immune globulin (human), render the proper surgical care, and consider the use of penicillin or oxytetracycline.

Emergency Medical Identification

Note on the patient's emergency medical identification device, the administration of fluid or adsorbed tetanus toxoid and—if given—tetanus immune globulin (human).

FINAL NOTE

A preliminary report is given on the second International Conference on Tetanus. The complete "Proceedings" will be published in 1967.

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Peritoneal Lavage in Control of Edema

Report of Its Use in Chronic Renal Failure

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THE REMOVAL of massive edema when associated with chronic renal insufficiency often presents a serious management problem. Despite conservative therapy including the use of diuretics, digitalis, and dietary restrictions requiring long periods of hospitalization, it is frequently impossible to achieve a successful diuresis. In addition, digitalis intoxication and electrolyte imbalance may occur.

Peritoneal lavage has been suggested as an effective route of therapy for the treatment of edema,¹⁻³ but utilization of this procedure for the removal of edema fluid from patients with severe renal impairment has not been reported. It is the purpose of this paper to present the results obtained using peritoneal lavage in a group of four patients with edema and associated chronic renal failure who did not respond to conservative therapy. It is suggested that peritoneal lavage can play an important role in the long-term management of these patients.

Material and Methods

Twenty-three patients with impaired renal function and edema were admitted to the Metabolic Unit of Mount Sinai Hospital of Cleveland for evaluation and therapy. Each patient was treated with complete bed rest and a 500 mg. sodium diet. Fluids were restricted to 500 ml. per day. Spironolactones*, chlorothiazides† and merallurides‡ were given in the recommended therapeutic dosages, as was ethacrynic acid.§ Those patients who did not respond to this regimen were subjected to peritoneal lavage.

Peritoneal lavage was performed in the following manner: The abdomen was prepared with aqueous zephiran chloride and sterile drapings were applied to the area between the umbilicus and the symphysis pubis. The patient was anesthetized with procaine hydrochloride. A 4 inch No. 18 cardiac needle was inserted into the peritoneal cavity and 2000 cc. of commercially available dialysate, which had been previously warmed to body temperature, was allowed

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to run into the peritoneal cavity through an administration set. The No. 18 cardiac needle was then removed and a small skin incision was made at the site of the needle puncture. A polyethylene catheter** was then inserted with the aid of a trochar. The trochar was then removed and the tip of the catheter was maneuvered to lie in the pelvic gutter either on the right or left side.

Each peritoneal lavage was limited to 25 exchanges in a 36-hour period. An exchange was defined as the insertion of dialysate fluid, equilibration of the fluid in the peritoneal cavity, and drainage of the fluid. Attempts were made to remove 500 ml. of edema fluid during each of the first 10 exchanges and 300 ml. of edema fluid during each of the subsequent 15 exchanges. With this goal in mind, the glucose concentration of the dialysate was varied. A 1.5 per cent glucose concentration was always used for the first exchange. If the negative balance was less than 500 ml., then a 4.25 per cent glucose concentration was employed. If a negative balance of 500 ml. was still not achieved on any of the next three exchanges, then a 7 per cent glucose concentration was used. The patient's weight, blood urea nitrogen (BUN), and creatinine were measured before and after peritoneal lavage.

Results

Table 1 summarizes the pertinent admission data on the four patients who were selected for treatment with peritoneal lavage. Two of the patients were female, two were male, two were Negro, two were white. The severe degree of renal impairment in all four of the patients is evident from the elevated

Submitted August 5, 1966.

*Aldactone-A, Searle.

†Diuril, Merck Sharp & Dohme.

‡Mercurhydrin, Lakeside Lab.

§Kindly supplied by Merck Sharp & Dohme.

**Trocath, Don Baxter, Inc., Glendale, California.

TABLE 1. *Pertinent Admission Data*

Patient	Age	Race	Sex	BUN	Creatinine Clearance cc/min.	Diagnosis
M.W.	80	W	M	138	8 cc/min.	Chronic Pyelonephritis
C.A.	54	N	F	212	18 cc/min.	Chronic Pyelonephritis
C.J.	45	N	M	145	6 cc/min.	Arteriolar Nephrosclerosis
L.H.	55	W	F	110	6 cc/min.	Chronic Pyelonephritis

BUN (blood urea nitrogen) levels and the decreased creatinine clearances.

All four patients underwent extensive conservative therapy with little success, as illustrated in Table 2. Three of the patients were treated for 33 days and one patient for 28 days with digitalis, diuretics, and dietary restrictions. The weight loss was 0 to 3 pounds in all four patients. In sharp contrast are the results obtained after only 36 hours of peritoneal lavage. All four patients responded to this therapy with a weight loss of 17 to 22 pounds as shown in Table 2.

TABLE 2. *The Effectiveness of Peritoneal Lavage in the Treatment of Intractable Edema*

Patient	Duration of Conservative Therapy	Weight Loss on Conservative Therapy	Duration of Peritoneal Lavage	Weight Loss on Peritoneal Lavage
	days	lb.	hr.	lb.
M.W.	33	2	36	17
C.A.	28	3	36	22
C.J.	33	0	36	18
L.H.	33	2	36	21

The complications encountered in this series of treatments were minimal. The most frequent complication was pain, commonly experienced on either the insertion or withdrawal of the dialysate fluid. No instances of perforation, overt peritonitis, shock, or mental confusion occurred. Despite the fact that a 7 per cent glucose concentration was employed, no fluid balance problems were documented.

Case Reports

Case 1: M.W., an 80 year old white man, was admitted to the Metabolic Unit of Mount Sinai Hospital of Cleveland because of massive edema. A diagnosis of arteriosclerosis, hypertensive cardiovascular disease, diabetes mellitus, and chronic renal insufficiency secondary to chronic pyelonephritis had been previously made. The onset of congestive heart failure had occurred one year prior to admission and was characterized by dyspnea at rest and pedal edema. Digitalization and diuretic therapy had relieved these symptoms until two months prior to admission at which time he became bedridden because of increased dyspnea and a marked weight gain.

Physical examination revealed an alert elderly man with a blood pressure of 220/98, atrial fibrillation with a ventricular rate of 70 to 80 per minute, and respiratory rate 28. The fundi revealed a grade 2/6 hypertensive retinopathy. Dullness at both lung bases and cardiomegaly were present. The liver was palpable 4 centimeters inferior to the right costal margin. Massive edema of both the upper and lower extremities was associated with an abdominal fluid wave and marked edema of the abdominal wall.

After an unsuccessful trial of salt and water restriction, diuretic and digitalis therapy lasting 33 days (Table 2), he underwent peritoneal lavage. He lost 17 pounds and showed marked subjective and objective clinical improvement. However, 2 plus edema was still present.

Nine days later, despite reinstitution of diuretic therapy, he had regained 6 pounds. Peritoneal lavage was repeated, and he lost 15 pounds. At this time his edema was negligible, and he was discharged on diuretic therapy. Five weeks after the second peritoneal lavage he was still asymptomatic, had only minimal edema, and a slightly elevated BUN.

Case 2: C.A., a 54 year old Negro woman, had known hypertension and diabetes mellitus for the past eight years. The onset of left ventricular failure occurred two years prior to admission and was followed by right ventricular failure associated with severe pedal edema and a weight gain of 40 pounds. She was digitalized and given diuretics with no decrease in her edema and was therefore admitted to the Metabolic Unit of Mount Sinai Hospital of Cleveland for further therapy.

Physical examination revealed a well-developed obese Negro woman with a blood pressure of 200/110, pulse rate 84, and respiratory rate 16 per minute. Eye grounds revealed old hemorrhage and exudates, arteriolar narrowing, and AV nicking. The neck veins were distended at 45°. Moist rales were present bilaterally. The point of maximum cardiac impulse was in the sixth intercostal space 3 centimeters to the left of the midclavicular line. Her liver could not be palpated because of her obesity and massive edema of the abdominal wall. There was edema of the lower extremities which extended to the thighs.

After failing to respond to four weeks of diuretic therapy, peritoneal lavage was performed and she lost 22 pounds (Table 2). The lavage was discontinued after 36 hours, although some edema was still present. In spite of the reinstitution of diuretic therapy, she gained 9 pounds during the week following peritoneal lavage and her edema worsened. Peritoneal lavage was repeated and she lost 21 pounds. After this second treatment, her edema and rales disappeared and she became ambulatory. During the next four weeks she lost an additional 9 pounds as a result of diuretic therapy, and she has been maintained on diuretics only since that time.

Case 3: C.J., a 45 year old Negro man, was admitted to the Metabolic Unit of Mount Sinai Hospital of Cleveland because of fluid retention associated with chronic renal insufficiency due to arteriolar nephrosclerosis and left ventricular failure secondary to hypertensive cardiovascular disease. Early in the course of his disease, a good response was achieved with sodium and protein restrictions, anti-hypertensive medications, digitalis, and diuretics. However, his azotemia and edema worsened and he subsequently became totally unresponsive to this regimen.

Physical examination revealed a well-developed and chronically ill man with a blood pressure of 190/120, pulse rate 84, and respiratory rate 16 per minute. The jugular veins were distended at 45°. Fundi revealed a grade 3/6 hypertensive retinopathy. Fine rales were present in both lungs and were associated with dullness of the left base posteriorly. The apex impulse was palpable 3 centimeters to the left of the midclavicular line in the sixth intercostal space. The liver was palpable 4 centimeters inferior to the right costal margin. There was massive edema of the lower extremities involving the thighs.

He failed to respond to conservative therapy after 33 days and was therefore subjected to peritoneal lavage (Table 2), which he tolerated well. Although bedridden at the beginning of treatment, a few hours after peritoneal

lavage was discontinued he was ambulatory and, although weak, was markedly improved.

He was discharged on maintenance doses of diuretics. Despite this therapy, his edema reaccumulated rapidly and for the following five months it was necessary to control him by re-instituting peritoneal lavage once every three weeks for 36 hours.

Case 4: L.H., a 55 year old white woman, was admitted to the Metabolic Unit of Mount Sinai Hospital of Cleveland with a diagnosis of coronary artery disease, chronic bronchitis, and chronic renal insufficiency secondary to chronic pyelonephritis. Two years prior to admission, she developed dyspnea at rest associated with periorbital and pedal edema and was treated with salt and protein restrictions, digitalis, and diuretics. During the following months her response to the regimen decreased progressively and, after a rapid weight gain of 20 pounds, she became bedridden and was hospitalized.

Physical examination revealed a well-developed, well-oriented woman who appeared chronically ill. Her blood pressure was 90/60 with respirations of 20 per minute. There were inspiratory and expiratory wheezes throughout both lung fields. The sinus rhythm was associated with occasional premature beats. Right ventricular, as well as left ventricular activity was increased. Periorbital edema, as well as massive edema of the hands and lower extremities, including the thighs, was present. Despite edema of the abdominal wall, the liver could be palpated 6 centimeters inferior to the right costal margin.

After failing to respond to dietary and diuretic therapy in the hospital, she was subjected to peritoneal lavage (Table 2). Despite premature ventricular beats and hypotension prior to lavage, she tolerated the procedure well. Her edema reaccumulated, however, within two weeks after treatment despite continued fluid and sodium restrictions and diuretic therapy. As a result, peritoneal lavage was repeated. She continued to require treatment every three weeks in order to control her edema despite diuretic therapy between treatments for two and one-half months. Interim diuretic therapy was then discontinued and the patient was maintained on peritoneal lavage alone.

Discussion

Peritoneal lavage has been shown to be an effective mode of therapy in the treatment of edema in patients with compromised renal function as a result of end stage kidney disease. Utilization of this mode of therapy may tend to increase the ability of a patient to respond subsequently to diuretic therapy and peritoneal lavage may be discontinued. In our series of four patients, two (C.A. and M.W.) did, in fact, respond subsequently to maintenance doses of diuretics after the removal of a significant amount of edema fluid by peritoneal lavage. These two patients have been maintained since that time on only diuretic therapy.

On the other hand, peritoneal lavage can be successfully employed on a long-term basis for the control of patients who remain refractory to diuretics even after the removal of great amounts of edema fluid. Two of the patients in our series (C.J. and

L.H.) continued to be unresponsive to diuretics administered after peritoneal lavage (Table 3).

TABLE 3. *The Effects of Diuretic Therapy Between Peritoneal Lavages*

Patient	Average Weight Gain ^{on} Diuretic Therapy*	Average Weight Gain ^{off} Diuretic Therapy*
	lb.	lb.
C.J.	11	10½
L.H.	10	10½

*Represents an average of four determinations each for a 21-day period.

Following treatments with peritoneal lavage, both patients were discharged on maintenance doses of diuretics. Their discharge weights were not maintained however and, in fact, they gained an average of 10 and 11 pounds respectively during a series of four three-week periods (Table 3). After each three-week period it was necessary to repeat peritoneal lavage indicating the ineffectiveness of the maintenance diuretics in preventing the reaccumulation of edema fluid. The diuretics were therefore discontinued and the weight gains between peritoneal lavage remained essentially the same in a comparable series of four three-week periods (Table 3). Peritoneal lavage was reinstituted every three weeks on these two patients and they have been successfully controlled on this regimen alone.

Conclusion

Peritoneal lavage is an effective means of controlling edema in patients with impaired renal function who do not respond to dietary restrictions or the administration of digitalis and diuretics. The complications encountered with the procedure are minimal and it lends itself to long-term utilization in those patients who continue to demonstrate an inability to respond to conservative therapy.

From the Shirley and Maurice Saltzman Institute for Clinical Investigation of the Mount Sinai Hospital of Cleveland.

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The Authors wish to thank Mrs. Margaret Salman, R.N., for her technical assistance.

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Pneumoperitoneum

Case Report with Differential Diagnosis

GRANT E. DEGER, M.D.

PNEUMOPERITONEUM is usually a manifestation of gastrointestinal perforation and generally represents an acute surgical emergency. However, not all the causes of free abdominal air are catastrophic. The astute physician will recognize benign cases, especially in the female.

A case presentation will serve to introduce a discussion of the differential diagnosis of pneumoperitoneum.

Case Report

An 18 year old gravida II, Para II, white woman was admitted in acute abdominal distress four hours after the onset of her symptoms, and was submitted to an exploratory laparotomy shortly thereafter. She had developed severe, progressive, diffuse, and persistent abdominal pain, which radiated to the right clavicle. The pain later localized in the right lower quadrant.

The patient's temperature was 99.4°. Pulse rate 100 per minute. Blood pressure 144/80. Bowel sounds were present. There was diffuse tenderness, guarding and rigidity with maximal tenderness in the right lower quadrant. X-ray showed free air under the right diaphragm. The white blood cell count was 27,000 per cubic millimeter. A pregnancy test was negative.

The only finding at laparotomy was frothy fluid in the right paracolic gutter which yielded *Pseudomonas* on culture. A preoperative vaginal culture also yielded *Pseudomonas*. No other abnormalities were found during palpation of the abdominal and pelvic organs. The appendix was removed and proved to be normal on microscopic examination. Postoperatively she did well on chloramphenicol. An upper gastrointestinal and small bowel series done on the day of discharge was negative.

In retrospect it was learned that douching in the bathtub with a pint of vinegar water had preceded her abdominal pain by 20 minutes. She had held the bag several feet high and administered the douche through tubing with a plastic tip. Finishing she had dressed, drunk a cup of coffee, sat down, and then developed severe pain.

We feel this was a case of pneumoperitoneum induced by douching. Although one author recommends laparotomy for all symptomatic cases of pneumoperitoneum, surgery could have been avoided in this particular case.¹

We do know something of the natural history of such cases. This author read accounts of such douching accidents abstracted from the 19th century European literature. Clumsy douching pumps, syringes, and nozzles occasionally caused sudden severe abdominal and precordial pain, respiratory distress, and abdominal bloating. Treatment with opium alone brought the patient to health in 10 to 24 hours.²

The Author

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Women are predisposed to pneumoperitoneum. Douching, intercourse, knee-chest postpartum exercises, water skiing, insufflation testing, and even bending and stooping have caused it.³ The knee chest exercises can generate a negative intraperitoneal pressure of 90 mm of water.⁴ The physician who is alert to the foregoing possibilities can avoid surgical intervention in these otherwise self-limiting accidents.

Other benign instances of pneumoperitoneum have been associated with gastroscopy, air contrast studies of the colon, aerophagia, and even rupture of an emphysematous bleb next to the diaphragm.

Perforation of the gastrointestinal tract is of course the first diagnostic consideration. And in these cases laparotomy is usually more or less urgent depending on the etiology and clinical state of the patient. Duodenal and gastric ulcer perforation account for 90 per cent (excluding surgically induced free air). Other causes of gastrointestinal perforation are: trauma, diverticulitis, carcinoma, ulcerative colitis, gangrenous appendicitis, Meckle's diverticulum, amebiasis, typhoid ulcers, and *Ancylostoma duodenale* infestations.²

Summary

A case of pneumoperitoneum due to douching is presented, and the causes of pneumoperitoneum are discussed. The author feels that not all instances of this condition require surgery. Armed with a good history and a strong nervous system, the physician can institute conservative therapy where intestinal perforation is unlikely, especially in the female.

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Submitted June 22, 1966.

Torsion of the Gallbladder

Case Report and Discussion

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TORSION of the gallbladder is an uncommon indication for surgery upon this organ but one demanding astute surgical judgment to preclude catastrophic mortality. Only two cases have been diagnosed preoperatively since Wendel's original report in 1899.¹⁰ Approximately 204 cases have been reported.¹

Case Report

An 88 year old white woman was admitted to Mount Carmel Hospital because of right upper quadrant pain of two days' duration. The pain was of sudden onset in her sleep and at first it was localized to the lower chest and epigastrium, associated with nausea and vomiting. Aspirin and other medication did not bring relief. The pain subsequently became localized in her epigastrium and right upper quadrant; it was unrelenting and was aggravated by body movement. The patient denied a history of jaundice. Previous surgery included appendectomy and left inguinal herniorrhaphy with recurrence. She had also suffered from thrombophlebitis of the left leg following the herniorrhaphy.

Pertinent physical findings included tenderness and muscle spasm, but not muscle guarding, over the right upper quadrant. Bowel sounds were hypoactive. The patient appeared dehydrated. The initial blood count revealed a hemoglobin of 15 Gm., hematocrit 40 volume per cent, white blood cells 20,160/cu. mm. Serum amylase was normal. Serum electrolytes showed a potassium 3.0 mEq. per liter, sodium 137 mEq. per liter, CO₂ 30 mEq. per liter, chloride 90 mEq. per liter. Flat plate of the abdomen revealed scoliosis.

The diagnosis of acute cholecystitis was entertained. Fluid therapy and antibiotics were begun, and the following morning she was clinically improved. A right upper quadrant mass became palpable and some abdominal distention was noted.

The patient was prepared for surgery, and an abdominal exploration showed a hemorrhagic infarction of the gallbladder, which was hanging free and lying transversely below the liver edge. The organ was edematous, enlarged, and tense. Its mesenteric attachment was twisted several times in a clockwise direction. Detorsion was followed by partial decompression, making cholecystectomy technically simple. The cystic duct was noted to be long and to occupy the fossa of the gallbladder. Microscopic examination of the specimen showed hemorrhagic necrosis of the gallbladder wall with acute inflammation. No stones were found. The patient made an uneventful recovery.

Discussion

Approximately 4 per cent of humans have congenital floating gallbladder.^{4,5} Torsion of the gallbladder has been reported in the extremes of life, the

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average age being between 55 and 75 years.^{3,4,8} Sex incidence shows a ratio of two females to one male.

The cause of this condition is unknown. Most of the reported cases showed anomalous mesenteric attachment of the gallbladder and of the cystic duct to the liver.^{2,4,5} Gross and T. Case noted two varieties^{2,5}: the first involved a mesenteric attachment between the inferior hepatic surface to the whole length of the gallbladder and cystic duct (Fig. 1). In the second variety, as in the case reported, the lengthened cystic duct occupied the fossa of the gallbladder, while the gallbladder and its peritoneal covering hung freely in the abdominal cavity (Fig. 2). It has been postulated that clockwise rotation of the gallbladder was activated by peristaltic waves of a fasting stomach, and that counterclockwise rotation was related to activity of the transverse colon.^{2,6,8}

Patients with kyphoscoliosis, and thin elderly persons seem to be predisposed to torsion of the gallbladder because of the visceroptosis developing from loss of supporting fatty tissue.^{6,7} It is also conceivable that a sudden change in body position can cause a "wandering" gallbladder to undergo torsion. Inflammation and stone do not appear to influence torsion of the gallbladder, since the majority of the cases recorded were not associated with gallstones.^{1,2,8}

When torsion is incomplete, the presenting signs and symptoms are similar to those of acute obstructive cholecystitis. The typical story is that of an elderly woman admitted within a few hours after the sudden onset of right upper quadrant pain, and tenderness associated with nausea and vomiting. Indigestion

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Submitted August 12, 1966.

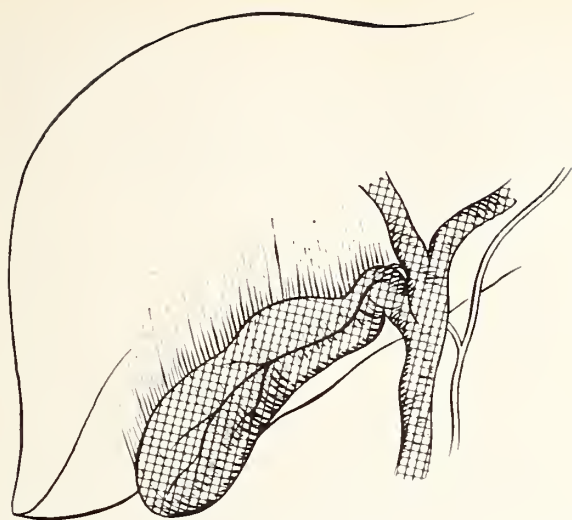


FIG. 1. Entire length of gallbladder and cystic duct attached to the inferior hepatic surface by a mesentery.

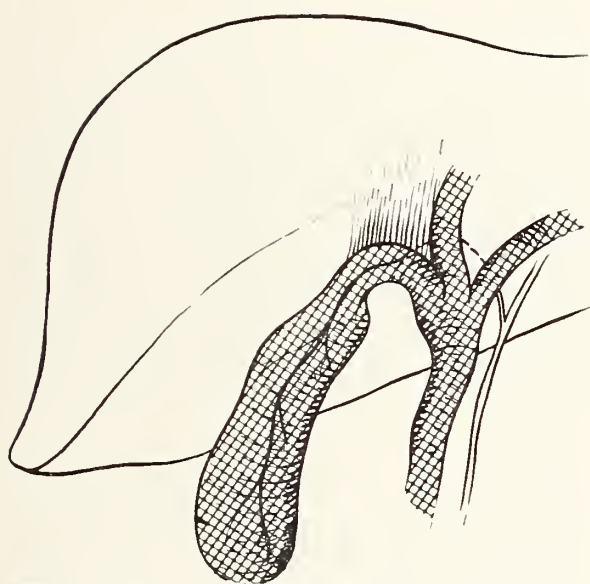


FIG. 2. Lengthened cystic duct attached with a mesentery only, leaving the whole gallbladder "wandering" free in the abdominal cavity.

and flatulence are common complaints. Jaundice is usually not present.

When torsion is complete with gangrene of the gallbladder, the signs and symptoms of shock and peritonitis may appear, a mass may be palpable, and the abdomen becomes distended and silent. Laboratory examination will occasionally reveal signs of dehydration and abnormal electrolyte imbalance. White blood count is usually elevated.

Successful treatment of acute torsion of the gallbladder requires early surgery, with detorsion and cholecystectomy. Cholecystostomy is not recommended because of the vascular involvement, with corresponding necrosis of the gallbladder. The operative mortality is around 4 per cent after early celiotomy in uncomplicated cases.^{1,4,9}

Summary

Torsion of the gallbladder is a relatively uncommon disease and presents a difficult diagnosis preoperatively. Acute cholecystitis, appendicitis, perforated ulcer, and bowel obstructions must be differentiated. The etiology is unknown, but several predisposing factors may be hypothesized.

Torsion of the gallbladder should be suspected in an elderly woman, and in a kyphoscoliotic patient with a short history of persistent abdominal pain.

Early surgical treatment is necessary to prevent a high mortality.

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IT MAY SOUND ACADEMIC to ask for such information, and unfortunately there are too many general practitioners who practice medicine without being academic, but I submit that to be academic is to be practical. The doctor who does not attempt to make a diagnosis, who treats his patient with all sorts of drugs and doesn't attempt to make a diagnosis is being very impractical because he is wasting the patient's time, sometimes the patient's life, and a lot of money, and if you stop to think of the money which is spent by the patient on drugs that are useless and not indicated, it would be far cheaper to do a proper diagnostic study. — Maxwell M. Wintrobe, M. D., Salt Lake City, in "Clinicopathological Conference," *The Ohio State Medical Journal*, 60:958-962, October 1964.

A Clinicopathological Conference

From The Ohio State University Hospital, Columbus, Ohio

Edited Under the Auspices of the Ohio Society of Pathologists

J. B. McMILLAN, M.B., Ch.B., *President*

PRESENTATION OF CASE

A 58 YEAR old white housewife was admitted to University Hospital with complaints of nausea, vomiting, and slight vaginal bleeding. A radical vulvectomy and bilateral groin dissection had been performed elsewhere five years prior to this admission because of squamous carcinoma of the vulva. No metastases were found in the lymph nodes. Following surgery the patient felt well until four to six weeks prior to this admission, when she lost her appetite and had nausea with occasional vomiting at various times following meals. She had no hematemesis, melena, jaundice, or change in bowel habits. Because the nausea and anorexia persisted, the patient ate very little solid food and for several days prior to admission ingested only liquids. Her weight six weeks prior to admission was 210 lbs., while on admission it had decreased to 173 lbs. During the last month her urinary output had decreased considerably. Previously she had urinated rather excessively, having had nocturia of two or three times for the past few years. She had some difficulty in starting the stream but did not complain of dysuria, hematuria, dribbling, or incontinence. She sought medical attention two days prior to admission when she developed generalized abdominal pain and noticed vaginal bleeding.

The past history revealed that diabetes mellitus had been diagnosed by her physician, who treated her with tolbutamide, 500 mg. each day, and diet restriction. Bilateral varicose veins had been stripped without complications sometime in the past. Two years after the vulvectomy she had an episode of slight vaginal bleeding, which subsided spontaneously. The family history revealed that a grandmother and a sister had carcinoma of the uterus. There was no family history of tuberculosis or diabetes.

Physical Examination

The patient was moderately obese. She was well oriented. The temperature was 98.6°F., pulse rate 88 per minute; respirations were 16 per minute and somewhat deep, and blood pressure was 146/74. The

Presented by

- W. T. Carter, M.D., Columbus, and
 - F. E. Cuppage, M.D., Columbus;
- Edited by Dr. Cuppage.

head, eyes, ears, nose, throat, chest and heart were described as within normal limits. The abdomen was obese and nontender. The liver was questionably palpated 2-3 cm. below the costal margin. She had slight costovertebral angle tenderness bilaterally. The extremities had stasis dermatitis but no significant edema. The pelvic examination revealed bilateral well-healed inguinal and perineal scars, prolapse of the uterus, and a third degree rectocele. There were neither adnexal masses nor abnormalities of the cervix. There was no significant vaginal bleeding at the time of examination.

Laboratory Data and Hospital Course

Because of the vaginal bleeding, the patient was admitted to the Gynecology service. A few days later it was noted that she was passing very little urine. The blood urea nitrogen (BUN) was 90 mg./100 ml., the creatinine 17.5 mg./100 ml., and the serum uric acid 15 mg./100 ml. The hemoglobin was 10.5 Gm.; the leukocyte and differential counts were normal. The urine had a specific gravity of 1.007 and contained 50 mg. of protein per 100 ml., occasional white cells, and 3 plus bacteria. The first urine culture was negative. A two-hour postprandial blood sugar was 100 mg./100 ml. with a fasting level of 92 mg. The inorganic phosphorus was 8.7 mg./100 ml.; alkaline phosphatase 4.6 units; calcium 3.4 mEq., CO₂ 8 mEq., sodium 135 mEq., potassium 4.3 mEq., and chloride 110 mEq. per liter.

The electrocardiogram revealed left axis deviation but was otherwise normal. A roentgenogram of the chest showed a slightly enlarged heart and a wide aorta consistent with hypertensive or arteriosclerotic heart disease. A right retrograde pyelogram showed no evidence of ureteral obstruction even though there

was some dilatation of the lower calyces. The radiologist noted some suggestion of an intrarenal mass. Laminograms of the kidney area revealed that the right kidney was larger than the average; the left kidney was not well visualized.

Because of the azotemia the patient was transferred to the Medical service. She was treated with fluids and bicarbonate with a gradual improvement in her electrolytes. Peritoneal dialysis was performed on several occasions but never functioned completely satisfactorily. *Escherichia coli* was cultured from a repeat urine specimen. The patient was then started on treatment with ampicillin.

A renogram done on the fourth hospital day showed decreased vascularity, decreased function, and no significant excretion curve. The patient's hemoglobin at this time was 10.1 Gm., hematocrit 32 per cent; sodium 135 mEq., potassium 4.3 mEq., chloride 110 mEq., and CO_2 8 mEq.; BUN 118 mg. The BUN gradually rose to 166 mg. and the creatinine to 21.6 mg. The increasing azotemia was accompanied by lethargy and confusion. Peritoneal dialysis was performed, with a fall in the BUN to 128 mg. but with little clinical improvement. A repeat urinalysis revealed a specific gravity of 1.009, a pH of 6, protein of 120 mg., a trace of glucose, no red blood cells, numerous white cells, Gram-negative rods, no casts, and rare epithelial cells. Throughout hospitalization her urinary output ranged from 300 to 600 cc. per day. The urines for the most part were negative or 1 plus for glucose; acetone was never present.

On the sixteenth hospital day the patient's blood pressure began to fall. During the next morning she became hypotensive, developed shallow respirations, and shortly thereafter died.

CLINICAL DISCUSSION

DR. BEMAN: We have a very interesting problem today and one that is really not too uncommon. The problem centers around an individual in the upper age brackets who comes into the hospital feeling reasonably well and then progressively deteriorates. This is a rather distressing situation, where a uremic state develops without much antecedent warning and the patient dies no matter how one treats him. What maintenance and definitive diagnostic methods are available to us in the extremely uremic patient? To open the discussion Dr. Carter will give us his impression of what was wrong, what wasn't wrong, and what else might have been done.

DR. CARTER: As Dr. Beman indicated, we are faced with a situation in which we have a 58 year old white woman who had an illness which was symptomatic for only two months and which rapidly terminated in renal failure with uremia. As we look at this we find that there was not a lot of diagnostic information available because of her critical state.

We are told that six years prior to her final admission the patient was diagnosed as having diabetes

mellitus, was treated for this and apparently had no associated difficulty. There is no mention about how this diagnosis was established. Five years prior to admission she was diagnosed as having squamous carcinoma of the vulva for which she was treated with surgery and apparently had recovered and done quite well from that, a course not too unusual for carcinoma of the vulva. The cure rate with this type of radical procedure in the absence of inguinal and femoral nodes is quite good, probably 50 per cent or so. I think I would tend to discount both of these disorders as having significance in her terminal disease.

As for the rest of the information that we are given, we have little that would indicate that there was anything wrong with the kidneys antedating the two months before she died other than the statement that she had some polyuria and nocturia and had noticed a diminution in her urine volume in the month or so prior to her admission to the hospital. Also important is that on physical examination, with the exception of some obesity, there were remarkably few positive findings. Certain information is useful to us in the differential diagnosis of renal failure in a woman in her late years. We know that she had a normal blood pressure. I would assume the other cardiovascular findings to be negative by their absence in the description. To clarify the information we are given I would like to ask Dr. Tzagournis four questions: First, on the description of the renogram, I would assume that this is a symmetrical appearance involving both kidneys?

DR. TZAGOURNIS: Yes, both kidneys showed decreased excretion and decreased blood flow.

DR. CARTER: This would then indicate to us that, whatever the disease might be, it would appear to be one that is attacking both kidneys uniformly. I am bothered by the fact that the two urinalyses described in the protocol are remarkably benign with the exception of some proteinuria. The second question is, Am I correct in assuming that this is an adequate description of the urine sediment on this patient, that there were no casts, no red cells seen, nothing but the proteinuria?

DR. TZAGOURNIS: I think I described that there were white cells.

DR. CARTER: Yes, but the white cells came late, after her retrograde pyelogram and perhaps even after she had been catheterized as she was developing increasing lethargy. But there is no description of red cells or casts.

The third point of additional information that I think would be of value to us is the serum protein values, either in terms of protein electrophoresis or a urine electrophoresis. Was either of these obtained?

DR. TZAGOURNIS: Neither was performed.

DR. CARTER: I think this is important in terms of our differential diagnosis, but not having them we can say little or nothing about it. Finally, I would

assume that there was no Bence-Jones determination done on the urine protein?

DR. TZAGOURNIS: No Bence-Jones protein was found.

DR. CARTER: I think it would be pertinent if at this time Dr. Harris would describe the x-rays.

Discussion of X-Rays

DR. HARRIS: The lungs are quite clear on the patient's chest films. The heart is just slightly enlarged. The aorta is somewhat dilated. Laminograms done after injection of contrast material demonstrated the right kidney. For some reason it focuses only on this right kidney and not on the left. There is no evidence of calcification. The kidney appears to be of moderate size, measuring approximately 14 cm. in length. It was probably somewhat smaller than this, considering the type of examination. The right retrograde pyelogram demonstrates that the kidney is of good size. There is some stretching of the calyces in the upper pole, suggesting the possibility that there may be more than one cyst within this kidney. There is also slight dilatation of a lower pole calyx.

DR. CARTER: Going back to the retrograde study, I would like to ask you two things about your thoughts on it. Is there distortion of the lower pole calyx?

DR. HARRIS: Although the lower pole calyx is enlarged and distorted, I cannot make a definite statement as to extravasation of contrast material or a defect in the pyramid. It could be due to an infiltration within the kidney or to the presence of multiple cysts. The fact that the patient has moderate-sized kidneys should exclude the so-called end-stage kidney. Perhaps a double-dosed intravenous pyelogram should have been attempted.

DR. BEMAN: I would like to ask Dr. Harris and Dr. Carter what happens to a person's kidneys with a double dose of contrast material. Is there any evidence that you damage the kidneys of people with chronic renal disease with all this contrast material?

DR. HARRIS: A group in Boston did this examination on a large number of patients with renal insufficiency and elevated serum creatinine, and I believe that in the majority of patients there was no elevation of the creatinine after the double-dose intravenous pyelogram in spite of the fact that at least five of the people in their studies had creatinines well over 25 when the double-dose study was done.

DR. CARTER: Many of us have the impression that we can aggravate existing renal disease by doing single- or double-dose intravenous pyelography. My impression has been that in the presence of inflammatory disease within the kidney, such as pyelonephritis, I have precipitated exacerbations of the primary disease by the pyelography. I think though that trying to prove a definite relationship is very difficult. On the other hand there is no question about the arteriography. When one introduces a

more concentrated form of Hypaque® directly into the renal vasculature through the artery in the presence of significant pre-existing parenchymal disease, further renal insufficiency often ensues, with a rise in BUN and creatinine and changes in the urinary sediment. I have seen a couple of biopsies done the day following arteriography, and there is a very destructive looking process going on.

DR. BEMAN: Let me ask you one more question: It seems to me that we have seen a good deal of unilateral retrograde pyelograms reported recently. What's the reason for this?

DR. CARTER: In our approach to a patient in renal failure, unless we have obvious reasons to account for it, we must exclude the presence of obstructive uropathy. If one can demonstrate a patent ureter on one side in a kidney that appears to be of normal size, I think this excludes obstruction as a factor in the renal failure. Because of the potential risk of retrograde pyelography we are satisfied with the demonstration of patency on one side.

Chronic Pyelonephritis?

What diagnoses would come to my mind in a case such as this? Obviously the first thing I would consider statistically is chronic pyelonephritis. I think this would be my number one working diagnosis in a woman of this age with no known history of renal disease who comes in with renal failure. A second consideration, but one which is not supported by any other information, is that she might have hypertensive cardiovascular disease with arteriolar nephrosclerosis. This would be another common cause for renal failure in a 58 year old woman. We have certain things that eliminate this. We do not have evidence of significant hypertensive vascular disease, either in terms of cardiac size, symptomatology, or eyeground changes. Because there is nothing to support the diagnosis of hypertensive vascular disease, I tend to exclude that as a possibility.

Since we are told that this woman is diabetic, she could conceivably have diabetic nephropathy. She has not really had symptomatology that would suggest diabetic nephropathy, in which circumstance we expect to find more proteinuria than this woman must have had. Frequently they will have gone through a nephrotic phase. She apparently did not. In general, when one sees diabetes with nephropathy significant enough to cause renal failure and death, almost invariably one will find eyeground changes accompanying this. Here we are told that the fundi were normal. These facts would, I think, tend to exclude significant diabetic nephropathy.

Chronic Glomerulonephritis?

Could she have chronic glomerulonephritis? This is certainly a distinct possibility. Chronic glomerulonephritis often has no antecedent history. These patients will present to us with some degree of renal failure

but no history that tells us of an acute episode of nephritis at any time. Her history dating back for several years of nocturia and some suggestion of polyuria would certainly go along with a chronic renal disease such as chronic glomerulonephritis. As you know, before these people go into their final azotemic state they go through a phase of polyuria. This may last anywhere from a few weeks to years, during which they do quite well. By having large volumes of urine they maintain body homeostasis. Against the diagnosis of chronic glomerulonephritis is what really amounts to a fairly benign urinary sediment. If she did not have red cells or casts of any type in the urine, I cannot make the diagnosis of glomerulonephritis.

I would narrow the diagnosis down to three possibilities: One is that she had a pyelonephritis, perhaps with an associated papillary necrosis. The second consideration is that this woman had polycystic renal disease. The third consideration that I would take into account is that she had renal amyloidosis. What are my reasons for considering these possibilities? As I said, pyelonephritis is not an uncommon disease in this age group and in women in particular. Most of these women will have had something to indicate that there was inflammatory or infectious disease going on within the G.U. system. They will have had one or more episodes of dysuria, urgency, frequency, or flank pain. Apparently this woman had none of those things, and again the urine sediment is somewhat against this.

We are told that on her initial examination there were occasional white cells and bacteria, but I don't know how this specimen was collected. It could well be that it was a voided specimen in which the bacteria mean little or nothing. On subsequent studies after she had been instrumented there were more white cells and bacteria again, and her urine culture became positive. But whether this was because she had underlying pyelonephritis or because bacteria were introduced at the time of the instrumentation I am unable to say. The only conclusive way that one may diagnose pyelonephritis due to bacterial infection is twofold: (1) There may be strongly suggestive evidence of bacterial pyelonephritis by seeing white cell casts in association with bacteria in the urine; or (2) the definitive diagnostic finding is the presence of bacteria within casts. In the absence of this, I think it is speculation as to whether or not this woman had pyelonephritis.

Papillary necrosis may be a cause of rapid renal failure. However, it is usually characterized by fever, an obvious septic course, and one would almost invariably find hematuria. It would be very unusual to have papillary necrosis without evidence of this in the urinary sediment.

Polycystic Disease?

Polycystic disease is still a distinct possibility and we do have some suggestive evidence of this with dis-

tortion of the calyceal system on the retrograde pyelogram. The kidney certainly is not markedly enlarged. This diagnosis would certainly be unusual with this history because almost invariably polycystic disease will have produced symptoms long before the patient begins to go into failure. They will have had one or more episodes of hemorrhage from rupture of a blood vessel in a cyst; they will have had intermittent episodes of flank pain, and almost a hundred per cent of these people will have symptomatic urinary tract infection. Her almost completely negative history in this regard is against the diagnosis of polycystic disease. The only information we have that would favor it is her age and some of the changes that we can see on this single retrograde pyelogram.

Amyloidosis

One of the considerations that I would favor most would be the presence of renal amyloidosis. I say this because it can be a disease that mimics all that we can see here, and it is the only disease that I am aware of in which the kidney is severely involved, leading to uremia, in which one finds as benign a urine as we have in this case. In renal amyloidosis proteinuria is always present, but one may have no other abnormal findings in the urinary sediment. The absence of hypertension would also favor this diagnosis.

So for the reasons that I have given, my first impression would be that this woman had renal amyloidosis, perhaps of a primary nature; the second consideration would be that she had pyelonephritis with some papillary necrosis; the third consideration would be that she had polycystic disease and failure associated with that. Terminally the patient may have had sepsis.

CLINICAL DIAGNOSIS

1. Renal amyloidosis, perhaps primary, with terminal uremia.
2. Sepsis.

PATHOLOGIC DIAGNOSIS

1. Polycystic disease of the kidneys with renal failure.
2. Bilateral bronchopneumonia.

DISCUSSION OF PATHOLOGY

DR. CUPPAGE: No evidence of recurrent carcinoma of the vulva was found at autopsy. The patient had an acute bronchopneumonia in both lower lobes, which likely played a role in her death. The pancreas had no evidence of insulin depletion. The Gomori aldehyde fuchsin stain revealed a normal size of islets and a normal amount of beta granules for the age of the patient.

The main diagnosis in this case is polycystic disease of the kidneys. The kidneys were large. The cortices and medullae contained many cysts of variable size which distorted the parenchyma. Many of

the cysts were lined by a low cuboidal or squamous appearing epithelium. Glomerular tufts extended into some cysts. A large amount of both loose and dense fibrous connective tissue surrounded the cysts. It is very important to differentiate the fibrous connective tissue around these tubules from the dysplastic response found mainly in the childhood form of polycystic disease. In the childhood dysplasia associated with polycystic disease one finds not only loose, primitive connective tissue but also smooth muscle around the tubules. This is not a case of dysplasia associated with polycystic disease. This was the normal fibrous connective tissue response around degenerating and atrophic tubules. In addition, there were some areas of focal chronic interstitial inflammation. This chronic inflammation may be either old bacterial pyelonephritis or simply a chronic response to injury of the nephrons by the cysts. There was no evidence of acute pyelonephritis at the time of autopsy.

Some of the glomeruli had focal areas of hypercellularity. Others contained exudative nodular lesions within the glomerular tufts which could pass for the exudative form of diabetic glomerulonephritis. Rarely both afferent and efferent arteriolar sclerosis could be demonstrated. As far as we know, this change in both afferent and efferent arterioles is specific for diabetes. An interesting additional finding was the presence of numerous large cysts within the lungs, likely associated with the renal lesions.

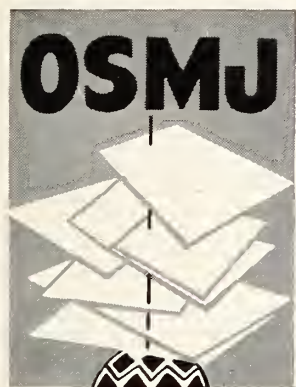
How can this case be classified among the several forms of cystic renal disease? We can easily exclude some of these forms, for example the simple cysts, either single or multiple, in one or both kidneys, which are related to retention or some other cause but do not significantly destroy the renal parenchyma. In addition, cysts may be found associated with infarcts, neoplasms, or abscesses. These secondary cysts can also be excluded in this instance. Two distinct forms of primary, diffus polycystic disease exist. One

occurs in infants and children, leading to progressive renal failure and early death. This form may or may not have renal dysplasia associated with it. It is a hereditary disease with an autosomal recessive inheritance. Although this may look very similar to the adult form, they probably are two different diseases.

The adult form of polycystic kidneys — again with large, multiple cysts that destroy much of the renal parenchyma — usually is not associated with dysplasia but may be associated with cysts in the liver, the lung, or the pancreas. Medullary cystic diseases, in which there are numerous small cysts within the medulla, can also be excluded. The form of cystic disease in this instance best falls into the adult form of polycystic renal disease.

It is one thing to make a diagnosis of polycystic disease, but far more important, I think, is an understanding of the pathogenesis of the disease. We know it is hereditary and most likely congenital, but how does the disease develop? In the development of a normal nephron, branches of the collecting tubules extend up into the metanephric blastema. These branches are extensions from the ureteric bud from the cloaca, forming the ureter. They go up into the metanephric blastema destined to become the adult kidney. The primitive tubules extend toward the periphery of the blastema and stimulate the formation of the glomeruli at their tips. The tubules after forming the glomerulus elongate into proximal and distal convoluted portions. This development is going on at birth in the fetus and continues during the first couple years of life. The theory is that the development of polycystic kidney comes from either the failure of portions of the tubule to unite, or a subsequent constriction of the primitive tubules. I don't think we can be certain, even with microdissection studies, just how this develops.

DRIVERS AND PRESCRIBERS. — We live in an age of therapy with potent drugs, and new weapons are coming to hand every year. These changes are to be welcomed; we cannot put back the clock even if we should wish to do so. The problems now posed by motor-cars and drugs are in many ways similar. We must ensure that the price of advance is not too high and that accidents are reduced to a minimum by foresight and care. Both are examined, licensed, and periodically reviewed. Roads and lines of communication of information are improved. The manufacturers are exhorted to introduce the latest safety devices and tests. However, in the final analysis, most depends on the driver and prescriber. — G. M. Wilson, M. D., D. Sc., F. R. C. P., Sheffield, England: *British Medical Journal*, 1:1065-1069, April 30, 1966.



NEWS AND *Organization Section*

Annual Roundup on Federal, State and Local Taxes for Physicians

THE close of another year and the beginning of a new one brings for most taxpayers the prospect of filing reports and paying taxes under a number of categories of federal, state, and local laws. This article is presented to furnish at least basic information on the several tax structures, deadlines for filing, forms to be completed, and potential liability of the taxpayer under each category.

Obviously only general data can be given in an article of this nature. For specific information on individual tax liability, the taxpayer is advised to consult authentic tax manuals, seek the advice of an authorized tax expert, or call upon personnel of the respective taxing agencies. A tax expert can point the way to many advantages under various tax laws as well as guide the taxpayer away from embarrassing errors.

The following tax categories are discussed in this article under respective headings:

- (1) Federal Income Tax, including payroll deductions.
- (2) The Federal Social Security program, including liability of physicians as employees or as self-employed persons, withholdings from employees' wages, etc.
- (3) Ohio Personal Property Tax, including the tax on tangible property used in business and the tax on intangible personal property such as stocks, bonds, investments, cash, and accounts receivable.
- (4) Ohio Workmen's Compensation tax, required

of those with three or more employees (optional for those with one or two), and the Disabled Workmen's Relief Fund tax.

(5) Ohio Sales and Use Tax.

(6) Ohio and Federal Unemployment Insurance Taxes.

(7) Municipal Payroll Tax, applying to residents of cities or villages which have such tax.

Information in this article is confined to those taxes on which the taxpayer or employer must file periodic returns. It does not include reviews of such taxes as those on real property, for which the taxpayer is billed directly, nor does it include discussion of many excise taxes for which the vendor of goods or services is primarily responsible; neither does it include a discussion of licenses.

FEDERAL INCOME TAX

The taxpayer will pay 1966 Federal Income Taxes under provisions of the Internal Revenue Act of 1954, subject to revisions by the Revenue Act of 1962, the Revenue Act of 1964, and certain Treasury Department regulations issued under authority of those provisions. The Social Security Amendments Act of 1965 affects self-employment tax as it pertains to rates. The Tax Adjustment Act of 1966 makes changes in regard to the amount of withholdings.

Who Must File

Every citizen or resident of the United States must file an income tax return if the gross income for the

year was \$600 or more for the person under age 65, or \$1200 for the person age 65 or over.

Forms and Payments

There are two types of returns, Form 1040A, and Form 1040.

Form 1040A may be used if the income was less than \$10,000 and consisted entirely of wages reported on Withholding Statements for such wages and not more than \$200 total of other wages, interest and dividends (excluding \$100 of dividends). When this form is used, if the income was under \$5,000, the Internal Revenue Service will figure the tax and send the taxpayer a bill or refund. If the income was between \$5,000 and \$10,000 the taxpayer must compute his own tax.

Form 1040 is used if the income is less than \$10,000 and the taxpayer must include income from sources not eligible for reporting on Form 1040A; wishes to deduct from wages certain reimbursed expenses, travel, transportation, etc.; or the taxpayer wishes to deduct credits for dividends and retirement income.

Form 1040 must be used if the income was more than \$10,000. Separate schedules, in addition to Form 1040, are provided for reporting business and professional income, capital transactions and other income. They are Schedules C, D and B.

Form 2106 may be used to support travel and transportation expenses.

Declaration of Estimated Tax

Virtually all physicians in private practice, and other persons who have income from sources other than wages subject to withholdings, are required to file declarations of estimated income tax, and to make periodic payments on estimated tax.

Regulations issued under authority of the Social Security Amendments of 1965 require self-employed persons to include their self-employment social security tax in their declaration of estimated tax, for tax periods beginning on and after January 1, 1967.

Specifically, every citizen or resident of the U.S. is required to make a declaration if his total estimated tax exceeds his withholdings (if any) by \$40 or more; and

(a) He can reasonably expect gross income exceeding —

(1) \$10,000 for a head of a household or a widow or widower entitled to the special tax rates;

(2) \$5,000 for other single individuals;

(3) \$5,000 for a married individual not entitled to file a joint declaration;

(4) \$5,000 for a married individual entitled to file a joint declaration, and the com-

bined income of both husband and wife can reasonably be expected to exceed \$10,000; or

(b) He can reasonably expect to receive more than \$200 from sources other than wages subject to withholdings.

A single declaration may be made on Form 1040-ES on or before April 15, 1967, for the 1967 taxable year; or, quarterly declarations may be made on or before April 15, June 15, September 15, 1967, and January 15, 1968.

The estimated tax may be paid in full with the declaration on or before April 15, or quarterly on the dates indicated above. For taxable years beginning in 1967, restrictions have been tightened as to allowable errors in reporting estimated tax. Through 1966, the estimated tax could be not lower than 70 per cent of actual tax liability without a penalty being imposed. Beginning in 1967 the estimate must be within 80 per cent of actual tax to avoid a penalty for most taxpayers. Amended declarations should be filed if the estimated income changes substantially.

Social security self-employment taxes are to be considered in estimating tax liability.

Husband and wife may file separate declarations and a joint final return, or may file a joint declaration and separate final returns.

Income-Splitting

Most married physicians will find it to their advantage to file joint returns with their wives, whether or not the spouse has income of her own. An unmarried person who qualifies as "head of household" may claim about one-half the tax benefit afforded a married couple on a joint return.

An unmarried widow or widower who maintains a home for his dependent children is allowed to use joint return rates in the two years following death of a spouse.

Adjusted Gross Income

For the person on salary, the total salary plus amounts received from interest, dividends, rent or from other sources constitutes the gross adjusted income.

The physician in private practice arrives at his adjusted gross income by deducting from cash receipts (or from total charges if he uses accrual method of reporting income) all items of expenditure necessary in earning his income. The more important items are described in the following sections.

Deductible Business Expenses

Office Rent — Rent paid to another person for office space may be deducted. That portion of rent paid for the office in a combined office-home may be deducted on a pro-rata basis of space used. If the physician owns his own home-office combination, he may not deduct rent, but may claim deprecia-

tion on that portion used as an office, again on a pro-rata basis.

Automobile — Cost of repair and upkeep of an automobile, including gasoline, service, etc., used in professional visits may be deducted. Salary of a chauffeur, sums paid for taxi or other transportation fare, for professional purposes may be deducted.

Depreciation may be deducted on an automobile used in professional business. Annual depreciation may be deducted on the basis of cost, less trade-in value, divided by the number of years the taxpayer uses the vehicle. The physician should seek the advice of a tax expert as to whether the "declining-balance method" of depreciation would be advantageous to him.

If an automobile is used both for professional and family purposes, a proportion of depreciation, cost of upkeep, etc., may be deducted, based primarily on mileage.

Damage to an automobile used in professional work, not done through negligence, and not covered by insurance, is a deductible item.

Professional Dues and Publications — Dues paid to professional associations to which the physician belongs, in the interest of his profession, are deductible. Publications purchased in the interest of his professional work become deductible items, as do publications purchased for the waiting room.

Refresher Courses — The Internal Revenue Service makes a distinction between expenses for advanced education and those for refresher courses (Section 1.162-5 of the IRS regulations).

Deductions may be made for "refresher" type courses, or those attended to maintain the skills of the physician and to keep him abreast of developments in his field of practice. Cost of education designed to prepare the practitioner to enter a specialty is not deductible.

Travel Expenses — The Revenue Act of 1962 deals extensively with travel expenses. Emphasis is placed on the distinction between travel time and expenses devoted to business or professional purposes and that used for vacation or entertainment. Regulations are less restrictive for the taxpayer if the trip does not exceed a week or if personal or vacation time does not exceed 25 per cent of the total time of the trip. Expenses for personal activities such as sightseeing, social visiting, personal entertaining or other recreation, are not deductible. A physician who is accompanied by his wife to a medical convention may deduct the amount that the trip would have cost him alone.

Entertainment Expenses — Section 4 of the Revenue Act of 1962, or Public Law 87-834, added new rules of proof and degree of business relationship for the Federal income tax treatment of certain business travel, gift, and entertainment expenses.

In general, a physician may deduct on his Federal income tax return the costs of entertainment, provided he can establish to the satisfaction of the Internal Revenue Service by appropriate evidence that such expenses are ordinary and necessary business expenses and clearly related to the production of business or professional income.

Exact records on each item are important. Here are criteria that may be used to determine the deductibility of entertainment expenses:

Specific purpose of entertainment; nature of the doctor's practice; period of time in practice; number of patients he already has; percentage of patients received as referrals; names of individuals entertained and reason why additional income could reasonably be expected from each; whether or not referrals were actually received from doctors entertained and any indication of the effect of the entertainment on these referrals; number of times individual doctors were entertained during the year, inasmuch as repeated entertainment indicates a personal motive; whether or not other doctors in the same type of practice in the locality have entertainment expenses.

Depreciation — Important principles in regard to claiming depreciation are contained in Treasury Department Publication No. 456, entitled *Depreciation, Guidelines and Rules*, revised August, 1964.

Depreciation may be claimed on virtually all equipment and furnishings of more or less permanent value used in practice; also on buildings used for business or professional purposes.

If the taxpayer is unfamiliar with methods of claiming depreciation, he may wish to consult a tax expert as to which method would be to his advantage — straight-line, declining-balance, double declining-balance, or sum-of-the-digits method.

Insurance Premiums — Premiums paid for insurance against professional losses are deductible. This includes insurance against damages for alleged malpractice, against liability for injuries to a physician's automobile while in use for professional purposes, and against loss from theft of professional equipment and damage to or loss of professional equipment by fire or otherwise. Premiums paid on life insurance are not deductible.

Premiums paid for disability insurance are deductible only if the policy specifies that benefits are for business or overhead expenses.

Other Business Expenses — Salaries of all persons whose duties are connected with professional work, and the employer's share on Social Security and other payments made in behalf of employees; items consumed-in-the-using such as medicines, bandages, laboratory supplies, etc.; uniforms or other garments used in professional work but not suitable for street wear; cost of telephones, telegrams, heat, light, water, etc.; Ohio and Federal gasoline tax, if this has not

been included in cost of gasoline; interest on business indebtedness; cost of replacement or repair of professional equipment lost or damaged by fire, theft, etc., not covered by insurance; certain legal expenses, etc.

Exemptions and Allowances

An exemption of \$600 may be claimed by the taxpayer for himself. He may also claim an exemption of \$600 for each dependent of close relationship, or for certain other dependents living in his household. To claim an exemption for a dependent, the taxpayer must have furnished over a half of the actual amount used for the dependent's support in the taxable year. Scholarships do not count as income to the child in determining the extent of parental support.

Exemption also is contingent upon the dependent, other than a child, having a net income of less than \$600 for the year. A child may earn \$600 or more and still qualify as a dependent if he is under 19 or a full-time student for five months during the year, or taking on-the-farm training, provided the taxpayer contributes more than half of his support.

An additional personal exemption of \$600 may be claimed by the taxpayer if he is over 65, another if he is blind; another if his spouse is blind; and still another if the spouse has reached the age of 65. (These provisions do not apply to dependents other than spouse.)

Nonbusiness Deductions

Regardless of whether or not the taxpayer claims business expenses, he may claim the following deductions if eligible to do so, providing that there is not a duplication of deductions under the two categories.

Medical, Dental, and Drug Expenses — Taxpayers will claim medical, dental, and drug expense deductions for 1966, the same as for the previous years. (Changes in regard to these deductions brought about by the Social Security Amendments Act of 1965 are effective for taxable years beginning January 1, 1967; not for 1966.)

Deductible items under these headings include the cost of diagnosis, care, mitigation, treatment or prevention of disease, or any treatment that affects a part or function of the body; also costs of transportation primarily for or essential to medical care and cost of travel prescribed for the relief of specific ailments. Included within the percentage deductions for this year are costs of medical and hospital insurance.

The following provisions and limitations apply to deductions for medical expenses:

The taxpayer under 65 may deduct medical, dental, and drug expenses which exceed 3 per cent of adjusted gross income, except only that amount paid for drugs that exceeds 1 per cent of adjusted gross income may be deducted.

The percentage limitation does not apply to medi-

cal and drug expenses for spouse or for dependent parents who are 65 years old or over.

The taxpayer over 65 may also disregard the percentage limitations on medical, dental, and drug deductions.

The deduction may not exceed \$5,000 multiplied by the number of exemptions claimed, with these further provisions: That no more than \$10,000 be deducted on a separate return; and no more than \$20,000 on a joint return, or a return filed by a surviving spouse or a head of a household. Larger limits apply to disabled persons aged 65 or over.

Deductions may not be claimed for medical items reimbursed by insurance.

Contributions, Gifts, etc. — Deductions up to 30 per cent may be claimed for contributions for religious, charitable, scientific, literary, educational, and similar purposes, including contributions to governmental agencies through which the gift is made for public purposes. Travel in behalf of volunteer charitable work is deductible at five cents a mile.

Under certain provisions, gifts above the 30 per cent ceiling may be carried over for as much as a five-year period.

Donations to private foundations remain under the 20 per cent ceiling, with certain exceptions. Still not eligible for deductions are gifts to candidates for public office, political parties, organizations seeking to benefit a particular group, organizations where there is a profit motive, subversive groups, organizations which attempt to influence legislation or engage in propaganda, etc. Gifts to fraternal or professional organizations are eligible for deductions only when the contribution goes to a special group set up within the organization for charitable, educational, or other approved purposes.

Interest — The taxpayer may deduct interest on a personal note to a bank or individual, a mortgage on his home, a life insurance loan if the interest is paid in cash, or interest on delinquent taxes.

Taxes — Deduction may be made for taxes paid on personal property or real estate, for city income taxes, retail sales taxes, and state gasoline taxes.

The following state and local taxes may not be deducted: Auto plate and driver license fees, cigarette and tobacco taxes, alcoholic beverage taxes, admission, occupancy and transfer taxes.

Casualty Losses and Thefts — The taxpayer may deduct losses due to destruction of property by fire, stolen property or cash, and storm damage, provided the amount is in excess of \$100 for each loss and provided the amount is not claimed as a business deduction and not covered by insurance.

Retirement Income

Pensions and annuity payments received by individuals fall into three classes for federal income tax purposes: Nontaxable, fully taxable, or partly taxable.

Certain items of retirement income also may be subject to credit, allowances varying according to whether the retired person is under age 65, over that age, or over age 72. A person who is receiving retirement income, therefore, would do well to check with an office of the Internal Revenue Service, or consult a tax expert.

Standard Deduction

In lieu of listing amounts paid for nonbusiness deductible items, under the Revenue Act of 1964, the taxpayer may elect to use the 10 per cent standard deduction, or the minimum standard deduction. However, both husband and wife must use the same method. The minimum standard deduction is computed as follows: \$200 (\$100 if married and filing separate returns) plus \$100 for each exemption claimed on Schedule A, of the return, including exemptions for age and blindness. The deduction is limited to \$1,000 (\$500 if married and filing a separate return). Consideration should be given to this provision in determining the amount to be entered on line 2 of the Tax Computation Schedule on page 2 of Form 1040-ES.

Other Provisions

Dividends paid out of a corporation's current or accumulated earnings are taxable. The first \$100 of such dividends are taxfree when the taxpayer takes the dividend exclusion. On a joint return the exclusion may be up to \$200. Dividends received in 1966 do not qualify for a dividend credit.

An individual who is 65 or older may exclude from gross income, any capital gain attributable to the first \$20,000 of the sales price of his personal residence. Provided the property has been owned and used by him as his principal residence for at least 5 years during the 8 year period preceding the sale.

The taxpayer who, because of employment, must engage a sitter for a child up to age 13, or for a physically or mentally defective dependent, may qualify for deductions on expenses for this purpose.

The taxpayer may not exclude sick pay from taxable income for the first 30-day period, unless the regular pay was reduced by 25 per cent or more.

Investment credit for the purchase of new equipment has been suspended as of October 10, 1966, except under certain conditions. Due to the recent enactment of this change, it is suggested that physicians who feel that this credit is involved in determining their taxes consult an accountant or tax expert. *The Journal* will publish additional information on this subject as soon as regulations are available.

Partnerships

The partnership itself is not subject to income tax, but is required to file an information return, Form 1065. Tax liability falls upon the individual partners. Simple agreements for the sharing of ex-

penses, co-ownership and maintenance of property, and the like, are not considered partnerships, unless a profit element also is involved.

Where an actual partnership exists, partners would do well to seek expert advice in regard to tax liability. An Opinion of the Ohio Attorney General given in 1961 permits professional men to associate as partnerships under Ohio limited partnership law and thus make themselves eligible for favorable tax action under the U. S. Internal Revenue Act.

Professional Corporations

In 1961, the Ohio Legislature enacted Sections 1785.01 through 1785.08 of the Ohio Revised Code, authorizing members of certain professions, including physicians, to form professional associations. A number of other states have enacted similar legislation. One of the primary purposes of the legislation was to make it possible for associations of professional persons to be treated as corporations for federal tax purposes.

A number of such professional associations have been incorporated under Ohio law, and have made application to IRS for special tax benefits. At latest report, none of these associations had been approved for special tax treatment. The Ohio State Medical Association has gone on record requesting the Internal Revenue Service to take no unfavorable action that would change regulations in regard to tax treatment of professional associations.

Provisions of the Keogh Law

The Keogh Act, or Public Law 87-792, permits physicians and other self-employed persons to claim tax deductions for a portion of the contributions made by them to pension and retirement plans for themselves and their employees.

The American Medical Association now has a retirement plan for qualified members and their employees, information on which may be obtained from the AMA Chicago office, or the Ohio State Medical Association office. (H. R. 13103, recently signed by the President, makes adjustments in this law, but changes are not effective until 1968.)

District Office and Districts

Income tax payments and returns must be made at or mailed to the office of the District Director of Internal Revenue for the district in which the taxpayer has his legal residence. There are two districts in Ohio. Counties comprising each district follow:

For the Cincinnati District — Director of Internal Revenue, 550 Main Street, Cincinnati, Ohio 45202, comprising the following counties: Adams, Athens, Brown, Butler, Clark, Clermont, Coshocton, Clinton, Delaware, Fairfield, Fayette, Franklin, Gallia, Greene, Guernsey, Hamilton, Highland, Hocking, Jackson, Knox, Lawrence, Licking, Madison, Marion, Meigs, Miami, Montgomery, Morgan, Morrow, Muskingum,

Noble, Perry, Pickaway, Pike, Preble, Ross, Scioto, Union, Vinton, Warren, and Washington.

For the Cleveland District—Director of Internal Revenue, 220 St. Clair Ave., N. W., Cleveland, Ohio 44113; comprising the following counties: Allen, Ashland, Ashtabula, Auglaize, Belmont, Carroll, Champaign, Columbiana, Crawford, Cuyahoga, Darke, Defiance, Erie, Fulton, Geauga, Hancock, Hardin, Harrison, Henry, Holmes, Huron, Jefferson, Lake, Logan, Lorain, Lucas, Mahoning, Medina, Mercer, Monroe, Ottawa, Paulding, Portage, Putnam, Richland, Sandusky, Seneca, Shelby, Stark, Summit, Trumbull, Tuscarawas, Van Wert, Wayne, Williams, Wood, and Wyandot.

INCOME TAX WITHHOLDINGS

Every employer who pays wages to one or more employees, where an employer-employee relationship exists, must withhold from such wages and pay over to the Federal Government periodically an amount prescribed by law.

The amount to be deducted from each pay check may be determined by referring to the *Employer's Tax Guide Circular E* after having the employee fill out Form W-4 to determine the number of exemptions he claims. The handbook is supplied by the District Office of the Director of Internal Revenue. As a result of the Tax Adjustment Act of 1966, a new Employer's Tax Guide Circular E went into effect for withholdings on and after May 1, 1966. The Act did not change the amount of taxes, but did adjust the rate for withholdings.

The amount deducted is paid to the District Office of the Director of Internal Revenue together with report on Form 941, for the calendar quarter, during the month immediately following the quarter for which deductions are made. Social Security taxes withheld from employees' wages and the employer's matching contributions are reported on this same form. Self-employment social security taxes are not reported on this form.

The employer is required to give each employee from whose wages he has withheld income tax during the year a statement in duplicate showing the amount of tax withheld and wages paid for that year. Forms W-2 in quadruplicate are supplied for this purpose. The original copy of Form W-2 is to be filed with the Employer's Quarterly Federal Tax Return, Form 941, for the last quarter. The second and third copies are furnished the employee and the fourth copy retained by the employer for his records. Statements must be furnished employees and reports made to the government between January 1 and January 31, for the previous year.

Deposit of Withholdings

An employer who withholds as much as \$100 per month for the purposes of income tax liability and F.I.C.A. liability (employer's and employee's shares) shall take these funds with Form 450 to a bank and

deposit them. The bank transmits this form to the Federal Reserve Bank in Cleveland for validation, after which it is returned directly to the employer. The depository receipt, Form 450, is then eligible for use.

Report of Funds Paid

Payments made during the year for interest of \$10 or more, rents, or commissions, not subject to withholdings of \$600 or more and paid to anyone other than a corporation, must be reported on Form 1099 and transmitted with Form 1096, on or before February 28 of the following year to the Director, Internal Revenue Service Center, 222 East Central Parkway, Cincinnati, Ohio 45202.

SOCIAL SECURITY TAXES

The Social Security Amendments of 1965 brought doctors of medicine under provisions of the Old-Age, Survivors, and Disability program, whether employees or self-employed persons.

For physicians on salary the social security tax is withheld as a payroll deduction. (See under heading Social Security for Employees.) Beginning with the taxable year 1966, interns and residents come under the same provisions as other employees for social security tax purposes.

For the calendar year 1966, the self-employed physician pays a rate of 6.15 per cent of the first \$6600 of net earnings. This amount includes a tax of 0.35 per cent on net earnings up to \$6600 applicable to the new hospital insurance program.

Beginning January 1, 1967, the self-employment tax will be 6.40 per cent of the first \$6600, which includes 0.50 per cent for hospital insurance.

The social security tax on self-employment earnings is to be paid quarterly with the Declaration of Estimated Tax (Form 1040ES).

The physician who has a part-time salaried position through which social security taxes are withheld need not pay the self-employment tax if social security taxes are withheld on income up to \$6600. If the salary subject to withholdings is less than \$6600, he must pay self-employment tax on the difference between the maximum and his salary.

The physician who paid his first social security tax for 1965 began to accumulate credit under the Old-Age, Survivors, and Disability program as of January 1, 1965. Interns and residents who came under coverage for the first time on January 1, 1966, began to accumulate credit at that date, except for previous non-professional employment.

Federal Health Insurance Programs

The Medicare program which went into effect July 1, 1966, is in two parts: (1) hospital insurance, and (2) medical insurance. Services in extended care facilities are not covered until January 1, 1967.

Physicians become eligible for benefits under both

(Continued on page 89)

(Continued from page 80)

parts of the program on the same basis as other individuals. Physicians who have recently come under social security coverage for the first time may disregard accumulation of credits for health insurance purposes. Beginning in 1968 accumulation of credit becomes a factor in eligibility.

Persons who are approaching age 65 and wish to take advantage of the hospital insurance program should notify the Social Security office at least a month before reaching age 65. Retirement is not a factor in eligibility for either the hospital insurance or the medical insurance programs.

Persons aged 65 and over are eligible for benefits under the medical program provided that they enroll during a specified enrollment period and agree to pay \$3 a month into the medical program fund. In general, persons approaching age 65 have an enrollment period of seven months beginning three months before they attain age 65. In the future, general enrollment periods will be from October 1 to December 31, in each odd year, beginning in 1967. No person may enroll more than three years after the close of the first enrollment period in which he could have enrolled.

Benefits under the medical program are for the individual enrollee only. The spouse who is aged 65 must enroll also if benefits are desired for both husband and wife.

Social Security for Employees

As employers, physicians will be interested in the following provisions of the law:

Every employer of one or more employees is required by law to deduct social security taxes from the employee's wages and to contribute a matching amount himself.

Through December 31, 1966, the rate is 4.2 per cent each for employee and employer, with deductions made on the first \$6600 of wages. This amount includes 0.35 per cent for the health insurance program.

Beginning January 1, 1967, the rate will be 4.4 per cent for each, which includes 0.5 per cent for the health insurance program.

The tax return and the informational return combined in one report is to be filed quarterly during the month after the quarter ends.

Employees Receiving Benefits

For the benefit of physicians who employ persons now receiving social security benefits, the following information is presented:

A worker under age 72 who is receiving benefits under the social security program will not lose any payments unless he makes more than \$1500 in a year. If he makes more than that amount certain deductions apply to his benefits. A person over age 72 may earn any amount and not lose benefits.

Both men and women may elect to receive benefits after age 62 at somewhat reduced rates. The widow

of an insured worker may elect to receive benefits after age 60 at reduced rates.

A disabled worker whose disability is expected to last for at least 12 months may qualify for disability benefits beginning with the seventh month of disability. The Social Security Amendments Act of 1965 also liberalized the requirements affecting people who are disabled by blindness.

Benefits to a child who is eligible to receive such benefits now continues through age 21, if the child is a full-time student in an accredited school. If the child is not a full-time student, benefits continue to the 18th birthday.

Not covered for social security purposes is work done by a child under 21 for his parent, by a husband for his wife, or by a wife for her husband. This applies also to foster or step-relationships. Services performed by or for "in-laws" and relatives other than those named are covered, provided a genuine employment relationship exists.

Under current provisions, work that a parent does for a son or daughter in the course of a trade or business is covered by Social Security. However, work done in the household of a son or daughter is not covered.

Domestic workers in private homes who receive wages of at least \$50 in a quarter are covered. In other words, if a taxpayer has a cleaning woman, or other domestic worker, only one day a week, she must be covered if she earns \$50 or more in a quarter (approximately \$3.85 per week). Domestic workers in farm homes come under the same provisions as farm workers.

A farm worker who earns \$150 in cash wages during the year must be covered. However, farm workers who perform agricultural services for an employer on 20 or more days during a calendar year for cash at a rate based on some unit of time must be covered regardless of the rate.

Only cash is considered in wages paid to domestic or farm workers, not wages in kind.

UNEMPLOYMENT TAX

Physicians or other employers who have three or more employees, including other physicians, nurses, receptionists, technicians, office workers, etc., are subject to the Ohio Unemployment Compensation Tax. Those who have four or more are liable also for the Federal Unemployment Insurance Tax.

In professional associations incorporated under Ohio S. B. 550, members of the group are counted as employees.

Ohio Unemployment Compensation Tax

In general, employment of three or more persons renders the employer liable for this tax. Excluded from the number of employees is a minor who does short-time work but whose principal occupation is that of student, and a person doing casual labor not in the course of the employer's regular business or

profession. Careful consideration should be given to an extra worker as to whether he should be included as an employee or as an independent contractor. A cleaning woman, for example, who works only a few hours a week, but who comes in regularly, would probably be classed as an employee. A physician who is in doubt as to his liability should request clarification from the Ohio Bureau of Unemployment Compensation, Columbus.

Reports are made during the month following each calendar quarter on forms supplied by the Bureau. The tax is established for each employer annually. A copy of the calculations made by the Bureau is mailed before the first of the year to each employer. This form also shows how the rate was calculated.

Rates for 1967 were not available when this article was prepared, but the rates will probably be somewhat reduced since the unemployment picture in Ohio has been improved, according to personnel in the Bureau. Rates for 1967 will start at 0.6 per cent and probably go no higher than 4.2 per cent. The same minimum has been in effect since 1963 through an emergency rate assessment. Only the first \$3,000 paid by any employer to any one individual "in employment" within a calendar year is taxable.

Penalties are specified in the Ohio Code for failure to comply with provisions of the law.

Liable employers should furnish a form BUC-400 to each employee upon separation. These forms may be obtained from the local employment office. If the employee files a claim for benefits, the bureau will request separation and wage information from the employer. These forms should be returned within seven days of receipt.

Federal Unemployment Tax

The Federal Unemployment Insurance Tax applies to employers who have four or more persons on their payrolls on 20 or more days in the calendar year, each of the 20 days being in different calendar weeks. It is payable to the District Director of Internal Revenue by January 31 for the previous year. The tax is on the first \$3,000 paid to an employee. A considerable credit is allowed on all payrolls which are reported to the state unemployment compensation agency, and on which the tax is paid (see under Ohio Unemployment Compensation Tax). If an employer has paid his state unemployment tax in full, the federal tax is reduced to a minimum.

OHIO WORKMEN'S COMPENSATION

The purpose of the Bureau of Workmen's Compensation is to maintain a Workmen's Compensation Insurance Fund from which to pay compensation to workmen for injury or occupational disease and compensation to dependents for death occasioned in the course of or arising out of employment.

Every employer in the state employing three or

more employees regularly in the same business is required to furnish the Bureau of Workmen's Compensation with specified information about employees he has had during the previous year, and to contribute to the State Insurance and Occupational Disease Fund in an amount based on the payroll and at a premium rate based on the class of risk. (The employer under certain circumstances may elect under bond to comply with the provisions of the law by self-insuring the risk.)

Employers of less than three employees may voluntarily subscribe to and obtain insurance in the Fund.

Insurance accounts are adjusted and reports made for the first half and second half of the calendar year. Reports are due with premiums attached by August 1 for the first half of the year, and by February 1 for the second half of the year. Another requirement is an advance permanent deposit based on eight months estimated payroll for the periods January 1 - August 31 and July 1 - February 28, respectively.

The Bureau of Workmen's Compensation comprises 16 regional offices in addition to the central office in Columbus.

Disabled Workmen's Relief Fund

Effective in 1959, the Ohio General Assembly increased permanent and total disability benefits and enacted Senate Bill No. 472 to finance this increase by levy of an excise tax on employers of 3 cents per \$100 of total aggregate gross payroll. This excise tax applies to employers of three or more employees, and to employers of less than three persons who have voluntarily subscribed to the Workmen's Compensation Insurance Fund; also self-insured employers. Report for the calendar year with premium is due by March 1 of the following year.

OHIO PERSONAL PROPERTY TAX

Returns under the Ohio Personal Property Tax Law must be made between February 15 and April 30 annually. One-half of the amount of the tax is paid when the return is filed, and the other half is due September 20.

Personal Property Tax Forms 910 and 911 may be obtained from the county auditor's office.

It must be kept in mind that tangibles to be listed include personal property used in business, such as a physician's office furniture, fixtures, equipment, supplies (including medicines), etc. Such tangible property should be listed at its true value. Counting the year of purchase as a half year, a depreciation of 10 per cent annually from cost will be allowed until such equipment reaches a value of 30 per cent. It should stop at that figure for a year. Then such office equipment may be reduced 2½ per cent each year until it reaches a minimum value of 20 per cent, which value should be kept as a utility value.

It should also be noted that personal investments

such as corporation stocks, notes or mortgages, etc., are also taxable and must be returned in the personal property tax report along with business property.

When a physician opens his practice (or a person starts in business) during the calendar year, he is required by law within 90 days of time of opening to list all of his taxable property, as of the date he engaged in practice. The valuation of all taxable property to be returned for taxation is determined by multiplying the value by the number of remaining months in the year and dividing the result by 12.

Forms 937 and 902, obtained from the County Auditor, must be filed with the Personal Property Tax return to obtain a lesser value than 20 per cent.

Returns should be filed in duplicate. The so-called tangible tax statutes are intricate and complicated so each physician having taxable personal property for listing should obtain competent advice in case of doubt as to the meaning of any of the provisions of the law.

Accounts receivable are to be listed in accordance with Section 57711.18 of the Revised Code part of which reads, "Claim for any deduction from net book value of accounts receivable or depreciated book value of personal property must be made in writing by the taxpayer at the time of making return," on supplementary tax form 902.

To arrive at a fair estimate of his current accounts receivable, the physician is advised to note after each account what he considers its value. If he believes the account can be collected in full, it should be listed at its full face value. Otherwise it should be listed at a percentage of its true value, or "no value" if that is the case. The total of these estimates is the amount to be entered as "current accounts receivable" and used in computing credits.

This procedure permits the physician to charge off bad debts. It also allows him to depreciate the actual value of accounts returned in the tax year, but which have decreased in actual value during that year.

All taxable personal property and credits used in business shall be listed as of the close of business of the last day of December, annually, or the last day of the fiscal year.

As defined in Section 5701.07 R. C., credits mean "the excess of the sum of all current accounts receivable and prepaid items used in business when added together estimating every such account and item at its true value in money, over and above the sum of current accounts payable of the business, other than taxes and assessments."

The same section states that "current accounts include items receivable or payable on demand or within one year from the date of inception, however evidenced."

It should be understood that there is no discrimination in the foregoing provisions against physicians. Every person who possesses intangible assets, such as accounts receivable, or any business or professional man who does business on a

credit basis, must return his accounts receivable for taxation.

OHIO SALES AND USE TAX

Section 5739.02 Revised Code levies an excise on each retail sale made in Ohio of tangible personal property.

In Section 5739.01, under the definition "vendor," the Revised Code states: "Physicians, dentists, hospitals and veterinarians who are engaged in selling tangible personal property as received from others, such as eye glasses, mouth washes, dentifrices, or similar articles, are vendors."

Under the definition of "consumer," the Code states: "Physicians, dentists, hospitals, and blood banks operated by non-profit institutions and persons licensed to practice veterinary medicine, surgery and dentistry are consumers of all tangible personal property purchased by them in connection with the practice of medicine, dentistry, the rendition of hospital or blood bank service or the practice of veterinary medicine, surgery and dentistry."

The Ohio Use Tax Law, passed in 1936, supplements the Retail Sales Tax Law and imposes a tax on the same basis as the sales tax on purchases made outside the State. Its purpose is to protect Ohio merchants from discrimination. Many out-of-state firms have made arrangements with the Office of the Tax Commissioner to add the amount of the tax to invoices covering purchases by Ohio consumers, collecting the tax and paying it directly to the Department.

However, if a physician purchases drugs or supplies from an out-of-state firm which has not made such an arrangement with the Office of the Tax Commissioner, he is required to report such purchases to the Treasurer of State and pay the tax. Returns must be filed with the Treasurer by April 15 for purchases, during the period January 1 to March 31, and quarterly thereafter. The report is filed on Ohio Use Tax Form 1014, "The Quarterly Consumers Return."

Forms are routinely sent to physicians on record, who have been assigned a Use Tax account number. Physicians who have not been assigned an account number should write to the Office of the Tax Commissioner.

CITY PAYROLL TAXES

Many municipalities in Ohio have enacted laws imposing income taxes on wage earners and placing the primary responsibility on the employer to make payroll deductions, file forms and pay taxes to the city government. This responsibility falls upon a self-employed person, such as a physician in private practice.

Laws vary as to liability of a person who earns the major part of his income in one community and resides in another. The physician who moves into a new location would do well to inquire as to local tax laws.

OMPAC Chalks Up High Score . . .

Ohio Medical Political Action Committee Demonstrates Strength in First Big-Time Test of "Strong Right Arm"

THE Ohio Medical Political Action Committee chalked up high scores in 1966, and demonstrated that Ohio's "Strong Right Arm" can influence the course of political affairs. OMPAC was organized in 1964 and took some part in the election of that year, but 1966 marks the first real test of its strength.

Here are high points in the 1966 record:

- Almost 30 per cent of Ohio physician members of the State Association (2,989) made financial contributions to OMPAC-AMPAC. Contributions totalled approximately \$75,000.

- OMPAC rated high in the national ranking of states with respect to total funds raised. It was third, exceeded only by Pennsylvania and Illinois.

- OMPAC made political contributions totaling \$67,350.00. Of this amount, \$58,000 went to support committees of candidates for the U. S. Congress, and \$9,350.00 to committees working for candidates for the Ohio Legislature.

- Of the total number of candidates for Congress and the Ohio General Assembly, OMPAC made financial contributions to 51. Of this number, 45 were elected.

- OMPAC made financial contributions to the local support committees of ten Ohio candidates for the United States House of Representatives.

- Of the Congressional candidates who were supported financially by OMPAC, nine were elected at the General Election on November 8.

- OMPAC also made financial contributions to the campaign committees of 14 candidates for the Ohio Senate, and the campaign committees of 27 candidates for the Ohio House of Representatives.

- Twelve Ohio Senatorial candidates who were aided by OMPAC were elected.

- Twenty-four candidates for the Ohio House who received financial help from OMPAC were elected.

- Physicians and their wives took active parts in political affairs in Ohio this year in unprecedented numbers.

Worthy Accomplishments

In announcing results of OMPAC's participation, Dr. Frank H. Mayfield, Cincinnati, chairman of the OMPAC Board, said: "The medical profession of Ohio can be proud of its political accomplishments in 1966. OMPAC, the political arm of the profession, made an outstanding record. Ohio Medicine

played an important role in the election of a large number of well-qualified and substantial candidates for seats in the U. S. Congress and in the Ohio General Assembly."

Dr. Mayfield further pointed out that a substantial number of successful candidates for Congress, the Ohio Senate, and Ohio House, although not receiving financial aid from OMPAC, did receive fine support from individual physicians in their respective districts.

The standing policy of OMPAC, Dr. Mayfield said, is to make financial contributions only to candidates engaged in unusually close races and in need of funds over and above those furnished from the party's treasury or from interested friends and supporters.

How to Meet Future Challenges

Applying to OMPAC the adage of storing up for a rainy day, Dr. Mayfield urged the medical profession of Ohio to build up its resources in 1967. The big push will come in 1968 — critical battles will take place in that year, and 1968 will bring another general election of supreme importance.

OMPAC cannot afford to rest on its laurels, Dr. Mayfield declared. Political activity must be an 'round-the-clock endeavor. "Those engaged in political activity on an organized basis must constantly work hard at the job, especially the job of building up financial reserves which can be used when the firing starts — when the campaigns get underway.

OMPAC ended 1966 with a modest reserve — just enough to meet necessary expenses incidental to keeping the organization alive and in business. Expenses of operating and administering OMPAC during 1966 amounted to between five and six per cent of income — a conservative figure for an operation of this kind.

To keep Medicine's "Strong Right Arm" in condition for the 1968 campaigns, OMPAC must have financial support and active participation of large numbers of Ohio physicians, Dr. Mayfield emphasized. Support is welcome from persons other than physicians, if they wish to give, he added.

It is imperative that more than the 3,000 physicians who gave to OMPAC in 1966 should contribute in 1967 and again in 1968, Dr. Mayfield said, so that OMPAC which has proved itself a potent political force can continue to make itself felt.

The County Medical Society combined billing procedure which worked so well in 1966, will continue in effect for 1967.

Physicians who have not yet paid their 1967 Association
(Continued on Page 97)

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Nutritional reinforcement for those who can't
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antidepressant for a gentle "mood" uplift...

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MEDITRATIC also provides *nutritional reinforcement—blood-building factors and vitamin supplementation*. It contributes a gentle "mood" uplift through methamphetamine HCl.

Three different dosage forms—Liquid, Tablets, and Capsules—offer convenience and variety.

MEDITRATIC Liquid

Each 15 cc. (3 teaspoonfuls) contains:

*Conjugated estrogens—equine (Premarin®)	0.25 mg.
Methyltestosterone	2.5 mg.
Thiamine HCl	5.0 mg.
Cyanocobalamin	1.5 mcg.
Methamphetamine HCl	1.0 mg.

Contains 15% alcohol

MEDITRATIC Tablets and Capsules

Each MEDITRATIC Tablet or Capsule contains:

*Conjugated estrogens—equine (Premarin®)	0.25 mg.
Methyltestosterone	2.5 mg.
Ascorbic acid	100.0 mg.
Cyanocobalamin	2.5 mcg.
Intrinsic factor concentrate	8.0 mg.
Thiamine mononitrate	10.0 mg.
Riboflavin	5.0 mg.
Niacinamide	50.0 mg.
Pyridoxine HCl	3.0 mg.
Calc. pantothenate	20.0 mg.
Ferrous sulfate exsic.	30.0 mg.
Methamphetamine HCl	1.0 mg.

*Orally active, water-soluble conjugated estrogens derived from pregnant mares' urine and standardized in terms of the weight of active, water-soluble estrogen content.

MEDITRATIC helps keep the older patient alert and active; helps relieve general malaise, easy fatigability, vague pains in the bones and joints, loss of appetite, and lack of interest usually associated with declining gonadal hormone secretion.

CONTRAINDICATION: Carcinoma of the prostate, due to methyltestosterone component.

WARNING: Some patients with pernicious anemia may not respond to treatment with the Tablets or Capsules, nor is cessation of response predictable. Periodic examinations and laboratory studies of pernicious anemia patients are essential and recommended.

SIDE EFFECTS: In addition to withdrawal bleeding, breast tenderness or hirsutism may occur.

SUGGESTED DOSAGES: *Male and female:* 3 teaspoonfuls of Liquid, 1 Tablet, or 1 Capsule, daily or as required.

In the female: To avoid continuous stimulation of breast and uterus, cyclic therapy is recommended (3 week regimen with 1 week rest period—Withdrawal bleeding may occur during this 1 week rest period).

In the male: A careful check should be made on the status of the prostate gland when therapy is given for protracted intervals.

SUPPLIED: No. 910 — MEDITRATIC Liquid, in bottles of 16 fluidounces and 1 gallon. No. 752 — MEDITRATIC Tablets, in bottles of 100 and 1,000. No. 252 — MEDITRATIC Capsules, in bottles of 30, 100, and 1,000.



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Outstanding Scientific Exhibits At OSMA Annual Meeting

LOOKING BACK to the 1966 OSMA Annual Meeting, this article is a review of two more of the outstanding Scientific Exhibits that were displayed in Cleveland, May 24-28 of last year. In keeping with a policy recommended by the Committee on Scientific Work and approved by The Council, awards were authorized for certain exhibits designated as outstanding by the judging committee. Seven exhibits were selected to receive the special honors which included mounted and engraved plaques, certificates and monetary awards. The committee designated three exhibits in the field of teaching, and three in the field of original investigation to receive respectively the gold, silver, and bronze awards, and named a seventh exhibit to receive a special award. Following is a brief description of two of these award-winning exhibits.

* * *

Special Award Goes to Exhibit On Motorbike Safety Theme

A Special Award was presented at the 1966 OSMA Annual Meeting to the exhibit entitled "Motorbike Safety," sponsored by a team of the Committee on Trauma of the Academy of Medicine of Cleveland. Members of the team were Dr. R. C. Waltz, Dr. Karl Alfred, Dr. Vernon Hacker, Dr. J. D. Osmond, and Dr. George Phalen.

With the provocative caption, "You May Meet the Nicest People on a Motorbike . . . If You Don't Drive Safely," the exhibit drew an unusual amount of attention.

The exhibit developed out of observations of a group of Cleveland area surgeons who noticed an alarming increase in the number of motorbike accident victims they were called upon to manage. A member of the exhibit team reported that the number of motorbiker registrations in Cleveland was expected to increase from 5,000 to more than 12,000 during 1966. One of the alarming aspects of this increase is in the fact that accidents are prone to occur among inexperienced riders and many of the increasing numbers of riders are inexperienced.

Unfortunately motorbike injuries have been discussed in a negative way, with the implication that motorbike riding is in itself dangerous. The exhibit sponsors believe that the public press is frequently at fault in this respect. Such an implication to the group of young enthusiasts would be of no more avail than trying to keep a skiing enthusiast from his favorite sport by warning him that he might break a leg. Menace though the motorbike may be, riding is fun and the custom is here to stay, the sponsors assert.

The Academy of Medicine of Cleveland, with the help of the Cleveland Health Museum, the Cleve-

land Surgical Society, Cleveland Orthopaedic Club, Ohio Committee on Trauma of the American College of Surgeons, the Cleveland Safety Society, and the MEND program of Western Reserve University, constructed the exhibit depicting the problems of motorbike accidents with emphasis on prevention. Primary messages in the exhibit included defensive driving, use of proper safety equipment, and personal protection. The exhibit was slanted expressly toward education of high school and college students and their parents.

The exhibit was assembled around the advertising theme of one of the leading motorbike manufacturers. Some of the "nice people" you meet if you don't drive safely were pictured in kodachromes: The ambulance driver, policeman, surgeon, nurse, etc. Other illustrations included x-rays of an entire skeleton showing fractures and repair. One panel contained a case history of a boy who lost his leg. Another panel specified what riders may do to avoid motorbike accidents and subsequent injury.

* * * *

Bronze Award in Investigation Goes to Rubella Exhibit

The Bronze Award in the Field of Original Investigation was presented to Dr. Gilbert M. Schiff, University of Cincinnati College of Medicine, for his exhibit entitled, "Let's Control Rubella in Ohio."

This exhibit consisted of a series of panels summarizing what is now known about rubella prophylaxis, with a prediction of what is ahead in the immediate future. The exhibit reflected the extensive research program in this field that is being sponsored in the Cincinnati area.

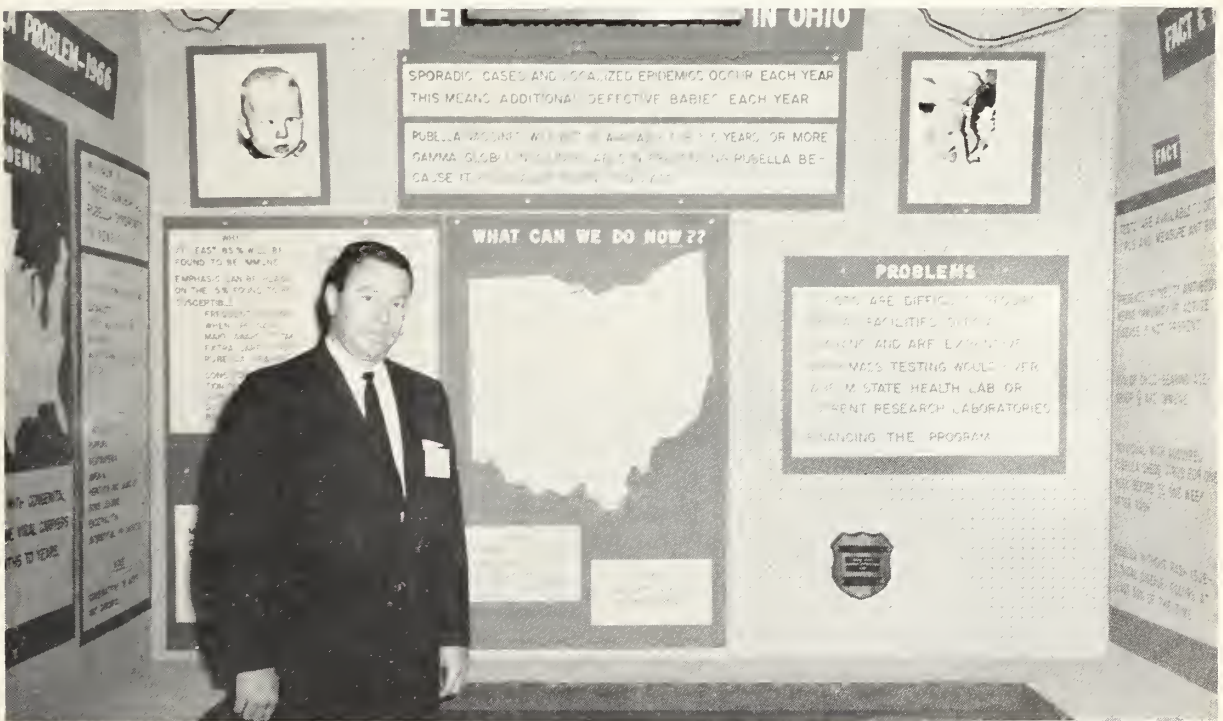
Here are a few of the facts presented:

Sporadic cases of rubella and localized epidemics

Award Winning Exhibits



This is the Special Award winning Scientific Exhibit at the 1966 OSM Annual Meeting on motorbike safety. Placing the award plaque on the exhibit is Dr. Lawrence C. Meredith, OSM President. See article on facing page for details.



Bronze Award winning exhibit in the field of original investigation is this one entitled, "Let's Control Rubella in Ohio," sponsored by Dr. Gilbert M. Schiff, of Cincinnati.

occur each year, with the result that additional defective babies was born.

Individuals with acquired rubella shed the virus for one week before and one week after rash.

Rubella without rash (subclinical disease) occurs at least 50 per cent of the time.

Tests are available to determine virus and measure antibodies.

Presence of neutralizing antibodies means immunity if active disease is not present.

Eighty-five per cent of child-bearing age women are immune; about 15 per cent lack neutralizing antibodies and hence are susceptible.

Determination of the immune status of pregnant women prior to exposure would be of immense value in the control of the rubella problem.

Rubella vaccines will not be available for 3 to 5 years or more. Gamma globulin is usually given too late and is therefore unreliable in preventing rubella.

In addition to Dr. Schiff's extensive investigation in this field he is an advocate of routine premarital testing for rubella immunity.

Singing Doctors of Missouri Produce Fourth Album

The Singing Doctors of Springfield, Missouri, after making three earlier hit record albums in the medical satire field, have now released a fourth volume entitled, "The Singing Doctors on Stage."

Proceeds from sale of the albums go toward expansion of a local scholarship fund for medical students. Albums are sold through the Greene County Medical Society, Professional Building, 2821 Eastmoor, Springfield, Mo. 65804, at \$4.25 each, postpaid and tax deductible.

Dr. Lawrence C. Meredith, Elyria, President of the Ohio State Medical Association, recently addressed a group of graduate students in the speech and hearing service at Kent State University, using as his topic, "The Pathology of Voice Abuse."

Members Need Not Sign Pledge On Vocational Rehab Vouchers

The Bureau of Vocational Rehabilitation, a state agency operated under the Ohio State Board of Education, will accept the same arrangement in regard to the nondiscrimination requirements of the Civil Rights Act as was approved by the Ohio Department of Public Welfare. In other words, physician members of the Ohio State Medical Association need not sign nondiscrimination compliance pledges when submitting vouchers.

The agreement is made on the understanding that members of OSMA pledge adherence to the *Principles of Medical Ethics*, which *Principles* preclude discrimination, and that they are subject to disciplinary action if charges of discrimination are made and substantiated.

Oscar L. Coddington, M. D., Medical Administrative Consultant to the Bureau of Vocational Rehabilitation, in making this announcement explained that the request-for-payment voucher of the agency is a form with the nondiscrimination statement printed on it. He wrote in part as follows:

"There are many others than physicians, and some physicians who are not members of the Ohio State Medical Association, who render services for the Bureau and who have not made any pledge of compliance. It will, therefore, probably be necessary for the vouchers to continue to have a statement of information related to civil rights included for them. In order to conserve the taxpayers' money it would probably be wise to use the same voucher for physicians who are members of OSMA. They could 'X' out the statement if they so desire, although it is placed below rather than above their signature."

Dr. Joseph E. Brown, chief of orthopaedic surgery at St. Luke's Hospital, Cleveland, is the new president-elect of the Clinical Orthopaedic Society. He will be installed as president of the national organization at its 1967 annual meeting in Columbus, October 11-13.

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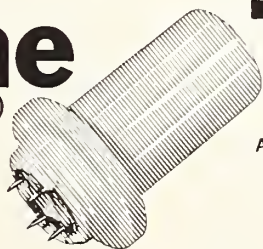
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reported for every
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of U.S. population.

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Ad Astra

George Dewey Blume, M. D., New Boston and Portsmouth; Eclectic Medical College, Cincinnati, 1925; aged 67; died November 6; member of the Ohio State Medical Association, the American Medical Association, and the American Academy of General Practice. Dr. Blume's practice in medicine and general surgery extended over 40 years, with most of that time in the Portsmouth area. He was a member of several Masonic bodies, the Elks Lodge, the Kiwanis Club, the Baptist Church, and the American Legion. Surviving are his widow and three sons.

Forrest Vesper Cress, M. D., Cincinnati; Eclectic Medical College, Cincinnati, 1919; aged 70; died November 26; member of the Ohio State Medical Association, the American Medical Association, and the American Academy of General Practice. Dr. Cress devoted all of his professional career to the general practice of medicine in the Cincinnati area. He is survived by his widow, a son, and a daughter.

John Walter Daehler, M. D., Portsmouth; Miami Medical College, Cincinnati, 1909; aged 82; died September 26; member of the Ohio State Medical Association and the American Medical Association. Member of a pioneer Scioto County family, Dr. Daehler returned there to practice after completing his internship in Cincinnati. In addition to his other professional activities, he was formerly county coroner and served for many years at the city health clinic. He also was examiner for several insurance companies and for the Selective Service. Affiliations included memberships in several Masonic bodies, the Exchange Club, and the Evangelical United Church of Christ. Dr. William E. Daehler, also of Portsmouth, is a son. Also surviving are his widow, two daughters and another son.

Frank J. Dawson, II, M. D., Columbus; McGill University Faculty of Medicine, 1955; aged 37; died November 29; member of the Ohio State Medical Association and the American Medical Association. A practicing orthopaedic surgeon in Columbus, Dr. Dawson formerly served with the Navy Medical Corps, being on active duty from 1959 to 1963. A member of the Catholic Church, he is survived by his widow, a daughter, his father, and a brother.

Richard D. Doughty, M. D., Spencerville; Eclectic Medical College, Cincinnati, 1904; aged 90; died November 14; former member of the Ohio State Medical Association and the American Medical Association. Dr. Doughty devoted virtually all of his professional career to practice in the Spencerville area, a period of some 62 years. Among local ac-

tivities, he was a former president of the Spencerville School Board. Surviving are his widow, two daughters, and a sister.

Louis J. Goldblatt, M. D., Stamford, Conn.; Jefferson Medical College of Philadelphia, 1916; aged 73; died November 17; former member of the Ohio State Medical Association and the American Medical Association. A practitioner of long standing in Youngstown, Dr. Goldblatt's specialty was obstetrics and gynecology. He also was known for his interest in medico-legal work. Living in retirement, he was making his home in Connecticut for about 11 years. Dr. Goldblatt was a veteran of World War I, a member of the Masonic Lodge, and a past president of the Youngstown Torch Club. His widow and a daughter survive.

George M. Guest, M. D., Savannah, Ga.; University of Cincinnati College of Medicine, 1922; aged 68; died November 25; former member of the Ohio State Medical Association and the American Medical Association; member of the American Pediatric Society, American Academy of Pediatrics, Central Society for Clinical Research, and the American Diabetes Association; diplomate of the American Board of Pediatrics. A practitioner of long standing in Cincinnati, Dr. Guest was formerly professor of pediatrics research, associated with the Children's Hospital Research Foundation. During World War II he served with the Office of Scientific Research and Development in Washington, and was decorated by the French Government for his work with the International Children's Center in Paris. He left Cincinnati in 1963 and was making his home with his foster son, who survives.

Gamble Samuel Hall, M. D., Napoleon; New York Medical College, 1941; aged 51; died November 23; member of the Ohio State Medical Association, the American Medical Association, Radiological Society of North America, and the American College of Radiology; diplomate of the American Board of Radiology. Residing in Henry County for the last three years, Dr. Hall was radiologist for several hospitals in the vicinity. He practiced in Dayton from 1950 to 1963, and formerly served with the Army Medical Corps. Survivors are his widow, two stepsons, and a sister.

Charles L. Harmer, M. D., Danville; Ohio Medical University, Columbus, 1902; aged 89; died November 24; member of the Ohio State Medical Association and the American Medical Association. A

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general practitioner of long standing, Dr. Harmer served for 32 years as Knox County coroner, and county health commissioner. Among survivors are his widow and a son.

Joseph Jeffery Lyons, M. D., Cleveland; Western Reserve University School of Medicine, 1943; aged 50; died on or about August 23; member of the Ohio State Medical Association and former member of the American Medical Association; diplomate of the American Board of Internal Medicine. Dr. Lyons' practice in Cleveland dates back to shortly after World War II, during which he was in military service.

William F. Marting, M. D., Ironton; Medical College of Ohio, Cincinnati, 1897; aged 91; died November 3; member of the Ohio State Medical Association and the American Medical Association. A practitioner of long standing in Ironton before his retirement, Dr. Marting operated the Charles S. Gray Deaconess Hospital there and later the Marting Hospital. He was a veteran of both the Spanish-American War and World War I. Among affiliations he was a member of the Masonic Lodge, the Elks Lodge, and the American Legion. His three surviving daughters are physicians—Dr. Esther Marting, of Cincinnati, who in private life is Mrs. Howard D. Fabing; Dr. Anne M. Alstott, and Dr. Miriam Marting, both of Ironton. A brother also survives.

Harvey Holmes Murphy, M. D., Barnesville; Ohio State University College of Medicine, 1938; aged 54; died November 4; member of the Ohio State Medical Association, the American Medical Association, and the American Academy of General Practice. A native of Barnesville, Dr. Murphy devoted virtually all of his professional career to practice in that vicinity. He was a member of the Methodist Church, the Rotary Club, Elks Lodge, and several Masonic bodies. Survivors are his widow, two daughters, a son, three sisters, and a brother.

Walter Armstrong Noble, M. D., Lima; Ohio State University College of Medicine, 1913; aged 75; died November 12; member of the Ohio State Medical Association, the American Medical Association, and the Aerospace Medical Association. A practitioner of long standing in the Lima area, Dr. Noble specialized in the field of EENT. Dr. William E. Noble, also of Lima and Allen County coroner, is his son. Other survivors are his widow and a sister.

Joseph Hill Rinehart, M. D., Springfield; Ohio State University College of Medicine, 1915; aged 75; died September 4; member of the Ohio State Medical Association. Dr. Rinehart took internship training at Springfield City Hospital in 1915 and 1916 and returned to practice surgery in Springfield after service during World War I.

John R. Seesholtz, M. D., Canton; Ohio State University College of Medicine, 1937; aged 54; died

November 11; member of the Ohio State Medical Association, the American Medical Association, and the American Academy of General Practice. A native of Canton, Dr. Seesholtz returned there to practice after five years of active duty in the Medical Corps during World War II. In medical organization work he was active in both the Stark County Medical Society and in the Canton Academy of Medicine. He also served on State Association committees and was for several terms a delegate to the OSMA House of Delegates. He was past president of the local Rotary Club, a member of the Historical Society, served on numerous committees of the Boy Scouts, was on the board of the Muscular Dystrophy group, and a former president of the Canton Board of Health. A member of the Catholic Church, he is survived by his widow, a daughter, two sons, and three sisters.

Roberta J. Shepard, M. D., Huntington, W. Va.; University of Tennessee College of Medicine, 1949; aged 47; died October 22 in Cleveland. An intern member of the Academy of Medicine of Cleveland from October, 1962 to September, 1963, Dr. Shepard was recently associated with the Chesapeake and Ohio Hospital in Huntington, W. Va.

Charles Francis Shook, M. D., Toledo; Creighton University School of Medicine, 1916; aged 72; died November 3; member of the Ohio State Medical Association, the American Medical Association, and the American College of Preventive Medicine; diplomate of the American Board of Preventive Medicine. A retired Army colonel, Dr. Shook was deputy chief surgeon of the Mediterranean and European theaters operating during World War II. In Toledo he was former medical director of Owens-Illinois, Inc. He formerly served on the AMA Council on Occupational Health and was consultant to the U. S. Army surgeon general.

Gordon Allen Smith, M. D., Elyria; Western Reserve University School of Medicine, 1936; aged 55; died October 27; member of the Ohio State Medical Association and the American Medical Association. Dr. Smith began his practice in Elyria in 1939 after completing his internship in Cleveland and residency training at Elyria Memorial Hospital. During World War II he served in the Army Air Corps. He was a member of the Methodist Church and the Masonic Lodge. Survivors include his widow and a son.

John J. Thornton, M. D., Cleveland; Harvard Medical School, 1934; aged 57; died November 14; member of the Ohio State Medical Association and the American Medical Association; Fellow of the American College of Surgeons; diplomate of the American Board of Surgery. Dr. Thornton began his practice of surgery in Cleveland in 1939 after taking three years of residency training there. During World War II he served in the Lakeside Hospital Unit. Among affiliations, he was a member of the Amateur Radio Emergency Corps. Survivors are his widow, a son, a daughter, a brother, and a sister.

Activities of County Societies...

First District

(COUNCILOR: PAUL N. IVINS, M. D., HAMILTON)

BUTLER

The Butler County Medical Society has established a policy of awarding medical college scholarship aid of \$1,000 to one or two advanced students yearly, the present school year to be the first.

The society membership has voted to split evenly the first scholarship gift between Robert S. Brenner, of Hamilton, and Gerald R. Reiter, of Hanover Township, near Hamilton.

In making the award, society officials stated they hoped the scholarship aid would ease the cost burden of the students' education, and that they will "practice medicine in Butler County."

Brenner is a third-year student at Ohio State University College of Medicine, and Reiter is in his third year at the University of Cincinnati College of Medicine.

The society will decide annually whether the scholarship aid will be awarded to one or two students. — *Middletown News-Journal*.

HAMILTON

"Medicine and the Motor Car-Crash Injuries" was the topic of discussion at the December 13 meeting of the Academy of Medicine of Cincinnati. Guest speaker was Dr. Preston A. Wade, professor of clinical surgery, Cornell Medical College.

Third District

(COUNCILOR: FREDERICK T. MERCHANT, M. D., MARION)

ALLEN

At the regular meeting of the Lima and Allen County Academy of Medicine held on November 15, 91 members and guests were present.

At this meeting on a formal motion the Lima and Allen County Academy of Medicine went on record as supporting the policy of The Council of the Ohio State Medical Association in regard to direct billing.

The annual election was carried out with Dr. T. L. Edwards, president for 1967, Dr. Nathan Kalb, president-elect, Dr. T. D. Allison, secretary-treasurer, and Dr. G. E. Wright elected to the Board of Censors.

At this meeting Dr. E. L. Burns of Toledo with his Ad Hoc Committee discussed "Regional Planning of Heart Disease, Cancer, and Stroke." It was felt by the academy that this was such an important feature of medicine today that a local committee was appointed to cooperate with Dr. Burns' committee

in Toledo. — T. D. Allison, M. D., Secretary-Treasurer.

SENECA

Dr. Lowell K. Good was elected president of the Seneca County Medical Society when the group met recently.

Other officers elected are Oswald G. Burkart, vice president; and W. F. Yarris, secretary-treasurer. — *The Republican Courier*, Findlay.

Fourth District

(COUNCILOR: ROBERT N. SMITH, M. D., TOLEDO)

LUCAS

The General Section of the Academy of Medicine of Toledo and Lucas County met on December 2. Annual committee reports were presented and discussed at the business meeting.

On December 9 physicians and dentists of the area held a joint meeting in the Academy Building. Speaker for the occasion was Herbert J. Bloom, D. D. S., chief of the Dental Department at Mt. Carmel Hospital, Detroit, who discussed experiences on the *S. S. Hope*.

The Sixty-Fifth Annual Meeting of the Academy will be held on January 12 at the Commodore Perry Hotel. Guest speaker for the occasion will be Henry J. Taylor whose topic will be "Looking Ahead at Home and Abroad."

SANDUSKY

Dr. E. C. Hiestand of Old Fort was elected president of the Sandusky County Medical Society Wednesday evening (Nov. 16) at a dinner meeting in Serwin's restaurant. He succeeds Dr. J. L. Zimmerman of Fremont.

Other new officers elected were Dr. J. G. Bushman, Bellevue, vice president, and Dr. E. F. Dierkscheide, Fremont, secretary-treasurer.

James Imboden, field representative of OMPAC, Columbus, discussed with the group the medical profession in relation to the recent political election.

Ten members and three guests attended. — *Fremont News Messenger*.

Fifth District

(COUNCILOR: P. JOHN ROBECHER, M. D., CLEVELAND)

LAKE

Dr. William C. Downing, Painesville surgeon, has been elected 1967 president of Lake County's Medical Society.

Serving with Dr. Downing for the coming year

are Dr. C. G. Madsen, Painesville, vice president, and Dr. G. P. Herman, Willoughby, secretary-treasurer. —*The Telegraph*, Painesville.

Sixth District

(COUNCILOR: EDWIN R. WESTBROOK, M. D., WARREN)

MAHONING

Members of the Mahoning County Medical Society heard a panel on fees at the regular November meeting. Panel guest was Francis Caulkins, head of Professional Management, Cleveland. Other panelists were Drs. U. H. Boening, R. L. Jenkins and A. K. Phillips, all members of the Medical Society. Panel moderator was Dr. J. W. Tandatnick.

Following the fees discussion, the membership passed a resolution supporting the Ohio State Medical Society recommendation that physicians not accept assignments, but use direct billing for all patients. Dr. F. A. Resch, president, presided.

The Mahoning County Medical Society held its annual medical assistants dinner and set a new attendance record for the event. Guests were office nurses, technicians, secretaries and receptionists. Special guest was Mrs. Candy Shufflebarger, president of the Mahoning County Medical Assistants Society. Dr. Jack Schreiber was master of ceremonies and provided an evening of magic and fun. Music was furnished by the Dixieland Docs, all local physicians

and dentists. The program was concluded with a fashion show and door prizes.

SUMMIT

The Summit County Medical Society held its monthly membership meeting on December 6 in the auditorium of Akron Children's Hospital. The Society's policy toward members and toward applicants involved in combined billing of patients by lay corporations was a topic of discussion.

TRUMBULL

A plea for better understanding among members of the medical and legal professions was made last night (Nov. 16) by Dr. Thomas T. Washam, Columbus, at a joint meeting of the Trumbull County Bar Association and the Trumbull County Medical Society at the Trumbull Country Club.

Dr. Washam, a physician and attorney who specializes in the medico-legal field, is executive secretary of the State Medical Board. He holds degrees in both professions.

"Both sides must strive to make certain that the basic principle of 'search for the truth' shall prevail in legal actions," the speaker declared.

Both Dr. John McGreevey, president of the medical group, and Atty. Joseph Saker, president of the bar, expressed hope that other meetings of a similar

(Continued on Page 114)

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References: 1. Pillsbury, D. M., Shelley, W. B., and Kligman, A. M.: A manual of cutaneous medicine, Philadelphia, Saunders, 1961, p. 79. 2. Barber, M., and Garrod, L. P.: Antibiotic and chemotherapy, Baltimore, Williams and Wilkins, 1963, p. 111.

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(Continued from Page 111)

nature will be held in the future to bring both professions into a close understanding of each other. — *Warren Tribune Chronicle*.

Ninth District

(COUNCILOR: OSCAR W. CLARKE, M. D., GALLIPOLIS)

GALLIA

Dr. Samuel L. Bossard, a member of the medical consultants staff of Gallipolis State Institute, was honored at a recent meeting of the Gallia County Medical Society. He was presented the 50-Year Award of the Ohio State Medical Association in appreciation of his life-long dedication to medicine.

Dr. Bossard joined the staff of the Gallipolis State Institute (then the Ohio Hospital for Epileptics) in 1920 and served there continuously until his retirement in 1964, with the exception of a service period during World War II. He is still active in medical organization work.

Further commenting on the award, Dr. F. E. Bournier, Gallipolis State Superintendent, said, "This is a very deserving honor that has been bestowed on Dr. Bossard, one which should be brought to the attention of all in the service of the Department." His words were quoted in statewide newsletter of the Ohio Division of Mental Hygiene.

Tenth District

(COUNCILOR: RICHARD L. FULTON, M. D., COLUMBUS)

FRANKLIN

The annual Christmas banquet of the Academy of Medicine of Columbus and Franklin County was held in the Neil House, Columbus, on December 3. Dinner music was provided by the John Bosca Trio of Musical Strollers, and entertainment by the Woman's Auxiliary Glee Club. For the evening of dancing, Al Waslon's Orchestra played.

The annual meeting of the Academy, at which newly elected officers will be installed is scheduled for January 17, also at the Neil House. Following a social hour and dinner, the Academy's business session will be held, followed by business sessions and programs of specialty societies.

The Academy cooperated with the Central Ohio Diabetes Association in a recent week-long diabetes detection program. Also cooperating in the screening program were the Columbus Department of Health and the Ohio Department of Health.

MADISON

Dr. Fred A. Lutz, of Mt. Sterling, was honored at a recent luncheon meeting of the Madison County Medical Society in the Madison County Hospital, London. At that time he was presented the 50-Year Award of the Ohio State Medical Association for

his faithful devotion to the principles of the profession during his long practice.

Dr. Richard L. Fulton, Columbus, Tenth District Councilor, made the presentation address, while Beale Lutz, of Columbus, pinned the award on his father's lapel. Dr. Sol Maggied, of West Jefferson, president of the Society, presided at the meeting.

Dr. Lutz, after serving in the Army Medical Corps during World War I, opened his practice in Mt. Sterling in 1919. He is still in practice.

Eleventh District

(COUNCILOR: WILLIAM R. SCHULTZ, WOOSTER)

LORAIN

New officers for 1967 were installed on December 13th when members of Lorain County Medical Society met at Oberlin Inn for the Annual Meeting. They take office as of January 1.

Dr. R. S. VanDervort of Elyria will succeed Dr. J. A. Cicerella of Lorain as president. President-elect for 1968 will be Dr. Delbert L. Fischer of Lorain. Installed as vice-president was Dr. D. E. Harrison of Elyria and Dr. William L. Hassler of Elyria will serve a three-year term as Censor, replacing Dr. W. E. Kishman of Lorain whose term of office expires. Dr. John B. McCoy of Elyria will continue for a second year as secretary-treasurer, and Dr. H. E. McDonald of Elyria and Dr. Charles Butrey of Lorain will remain in office as censors. Completing unexpired terms of office in 1967 as delegates to Ohio State Medical Association are Dr. Ben V. Myers of Elyria and Dr. James T. Stephens of Oberlin; alternate Delegates are Dr. William H. Miller of Elyria and Dr. Max L. Durfee of Oberlin.

The new president, Dr. VanDervort, is a native of Pennsylvania. He graduated from the University of Pennsylvania and has been a member of the Lorain County Medical Society, Ohio State Medical Association, and the American Medical Association since 1958. His specialty is Anesthesiology, and he has been a Diplomate of the American Board of Anesthesiologists since 1957. Dr. VanDervort also serves on the Ohio State Maternal Health Committee, and on the Planning and Co-ordinating Committee of the Elyria United Community Services.

Prior to the election of officers, a total of 126 members including their wives, met for a social hour and buffet-type dinner at the Inn. Immediately following dinner, a 15-minute film entitled "A Different Drum" was shown to the audience. This colorful film portrays the significance and potential of the Institute of Biochemical Research — a branch of the American Medical Association Education and Research Foundation, which opens a new pathway to medicine's future. More than just a research facility, the Institute is a place where outstanding scientists are free to explore the innerworkings of the living cell. Dr. C. T. Rusin of Lorain is chair-

man of the local committee of the AMA Education and Research Foundation.

Dr. Lawrence C. Meredith of Elyria, President of Ohio State Medical Association, addressed the group. During the business meeting which followed, President J. A. Cicerella in his address thanked the members for their loyal support, and outlined the accomplishments and activities of the Medical Society throughout 1966. Secretary-Treasurer John B. McCoy presented the financial report and budget for 1967, together with details of the membership status and the varied types of meetings held throughout the year. Reports received from the chairmen of several committees testified to the efficacy of the following throughout 1966 — Blood Bank, Cancer, Constitution, Education, Environmental and Public Health, Insurance, and Mediations Committees.

The membership stood in silent tribute to the memory of Dr. Gordon A. Smith following a memorial address by Dr. J. M. Strong.

Dr. Charles N. Horvath of Lorain and Dr. Rupert O. Clark of Oberlin were elected to Associate Membership in the Society.

A standing vote of thanks was accorded outgoing

officers and the new president, R. S. VanDervort, accepted his responsibilities with a brief outline of proposed endeavors for the year ahead.

MEDINA

The Diabetic Screening program conducted at the Medina County Fair in August by the Medina County Medical Society and the Medina County Health Department was declared a success by Dr. Aileen McKenzie, head of the Division of Chronic Diseases of the Ohio Department of Health. Some 1610 people were screened. A follow-up of initial screening resulted in discovery of a number of previously undiagnosed diabetics, who were referred to their family physicians.

The Medina County Medical Society was the recipient of an award from the Ohio Division, American Cancer Society, for notable assistance in the "Crusade to Conquer Cancer." Through efforts of the Society, more than 4500 students were shown films on the possible effects of smoking. Film showings were followed by question-and-answer periods in which members of the Society presided. The program won third prize in the State of Ohio.

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Woman's Auxiliary Highlights...

By MRS. S. L. MELTZER, Publicity Committee
Chairman, 2442 Dorman Dr., Portsmouth 45662

THERE is an anonymous quotation that has always been a favorite: "Every new baby comes with the message that God is not yet discouraged with Man." I recall it now, I suppose, because of this New Year still in its swaddling clothes and the hope that it brings, in spite of a troubled world. Doctors' wives have an important stake in the New Year because in their own way they can do so much to help make it a better year. Not in any miraculous way, to be sure—but that time-worn "every little bit helps" still holds fast, to my way of thinking. Each January I like to focus the spotlight of attention on the National Auxiliary's beautifully significant "Let the helping hands of the doctor's wife reflect and enrich his dedicated service."

Mental Health

Mrs. Christopher A. Colombi, state mental health chairman, has coined this meaningful statement: "Information means understanding which can be turned into action." In no one area of public health is there a more important starting point in this year of 1967 than that of mental health. Mrs. Colombi points out that each community needs leadership and support in planning and solving local needs. Education as a preventive measure is most important, she stresses.

The problem of child mental illness, the establishment of suicide prevention centers and the Community Mental Health Services Act are just a few

of the high points in the current mental health picture. Mrs. Colombi, a past state president who has also served at the National level, can be a source of tremendous help to local chairmen. She is another of those dedicated women who gives of her all and there is nothing she'd rather be doing right now than "giving her all" in this vital project of mental health.

Around the State

The Allen County group came up with a hum-dinger in middle November. It proved such an outstanding event that the *Lima News* gave it an almost full page spread. I quote from the story's lead: "A meeting like this 25 years ago would have been unthinkable: An afternoon get-together to discuss in naked terms the problems in marriage such as frigidity, pregnancy, sex, birth control, human love and Godly love, and family security. That's how Lima gynecologist Dr. Vernon A. Noble said it last week for the guest luncheon of the Auxiliary to the Lima and Allen County Academy of Medicine in the Milano Club."

Other panel members included: Dr. Leonard Lovshin, Cleveland Clinic internist; Rev. Donald Heintschel, associate pastor of St. John's Catholic Church; Dr. Nathan Kalb, Lima psychiatrist; and Mrs. A. Frank Portmann, doctor's wife, housewife, and mother of seven (she presented the feminine viewpoint).

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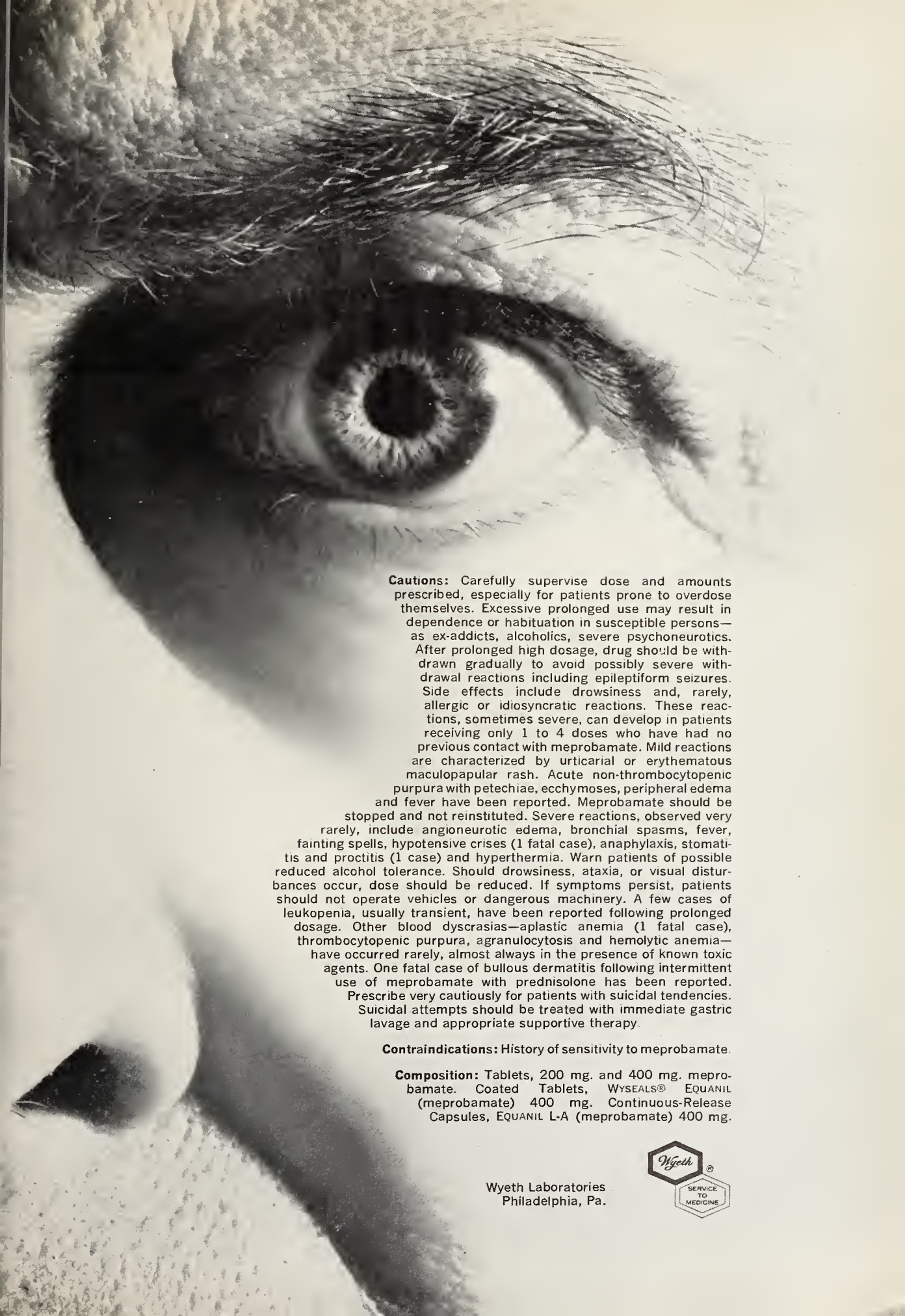


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stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Warn patients of possible reduced alcohol tolerance. Should drowsiness, ataxia, or visual disturbances occur, dose should be reduced. If symptoms persist, patients should not operate vehicles or dangerous machinery. A few cases of leukopenia, usually transient, have been reported following prolonged dosage. Other blood dyscrasias—aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia—have occurred rarely, almost always in the presence of known toxic agents. One fatal case of bullous dermatitis following intermittent use of meprobamate with prednisolone has been reported.

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A Tribute

Some 180 members and guests attended the luncheon meeting. Hostesses for the occasion were: Mrs. Fred Berlin, Mrs. Norman Browning, Mrs. J. W. Burke, chairman; Mrs. John Glorioso, Mrs. Nathan Kalb, Mrs. J. M. McBride, Mrs. J. H. McGavern, Mrs. K. O. Pajor and Mrs. Gene Wright.

Mrs. J. Frazier Jackson was hostess to the Columbian Auxiliary at its October meeting. It was the occasion of its twenty-fifth anniversary. Mrs. M. D. McCutcheon, charter president, presented each member with a gift booklet of the group's history. New fall fashions featured the style show with these auxiliary members serving as models: Mrs. Charles Gerace, Mrs. Janis Lauva, Mrs. William Horger, Mrs. H. F. Banfield, Mrs. J. M. Nedelkoff and Mrs. K. W. Turner. Donald Lynn, owner of Zacks, was commentator. Mrs. R. J. Bonistalli, auxiliary president, presided at the refreshment table.

Columbiana's November 15 meeting at the Inn Town Motel featured an international bazaar and a program presenting the students of the county's School for Retarded Children. It was a luncheon meeting in behalf of the group's mental health project. Handicraft, baked goods, and other bazaar gift items netted \$138 which has been given to the school. Mrs. Bonistalli explained a poster display "Life's Time Mental Health Plan" which depicts in cartoon form childhood, adolescence, and adulthood. Fourteen children of the school took part in the songs and dances which provided the entertainment. This feature of the afternoon was directed by Mrs. Janice Southall, leader. Mrs. William Banfield gave a community service report on a recent showing of the film "Dance Little Children" (regarding venereal diseases) to teachers of local public schools. Thirty members attended the luncheon at which these women served as hostesses: Mrs. J. A. Fraser, Mrs. J. M. Nedelkoff, Mrs. S. G. Sinclair and Mrs. Lawrence Wilson.

The Greene County auxiliary entertained 60 guests at a recent reception in honor of Dr. and Mrs. Paul Espey. Dr. Harold Tharp reviewed Dr. Espey's long medical career in Greene County. Dr. Clement Austria, president of the Medical Society, presented a gift to the one guest of honor while Mrs. Harold Ray presented a gift to the other guest of honor. Mrs. Ray and Mrs. Cary Gardner were cohostesses for the Sunday afternoon event. Lynn Warner, daughter of Dr. and Mrs. R. D. Warner, was in charge of the guest book. Virginia Tharp, daughter of Dr. and Mrs. Tharp, served at the punch bowl.

Dick Perry, author of *Vas You Ever in Zinzinnati?* was the featured speaker at *Hamilton County's* November luncheon meeting at the Fox and Crow Restaurant. Mrs. Donald E. Miller and Mrs. Eli Rubenstein were program cochairmen. Following Mr. Perry's lively talk, Mrs. Ben I. Friedman conducted a short business meeting. Christmas cards and handmade gift items were displayed and sold in the auxiliary's continuing efforts to raise funds for AMA-ERF. The hostess committee included: Mrs. Lester W. Sanders, Jr., Mrs. Hilmer W. Neumann, Mrs. John E. Albers, Mrs. Joseph Sebastiani, Mrs. Khames Saba and Mrs. Joseph Casper. Centerpieces at the luncheon featured a book jacket, a geranium (Cincinnati's official flower) and a pair of eyeglasses.

"Prospecting" for gold was a rather elegant pastime and feature of Cuyahoga County's annual Chrysanthemum Ball in November at the Statler Hilton Hotel Ballroom. The "mine" was a sandy treasure island, shaded by a palm tree. "Miners," dressed in evening gowns and tiaras, sifted for nuggets with small strainers rather than with picks and shovels. And waiting to award those who struck it rich were four teenage "ladies," daughters of doctors, holding gifts from a weatherbeaten sea chest. All the "strikes" benefitted the Auxiliary's new gen-

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eral philanthropy fund. Gold was also to be found in the flowers which give the ball its name. Large paper mums in gold and rust decorated the ballroom and the tables. The Cleveland Clinic Orchestra under the direction of Dr. Thomas F. Meaney provided outstanding entertainment. The Bob Larence Orchestra played for the dancing. Ball chairman was Mrs. Anthony H. Dindia, assisted by Mrs. Frank L. Meany. Mrs. Rudolf O. Cooks is Cuyahoga Auxiliary president.

Hovering around Lucas County's November meeting was the aura of Thanksgiving. The tables were unusually provocative with arrangements of ice carvings of the Horn of Plenty and striking fruit carvings. The speaker, Dr. Glidden L. Brooks, is president of the new Toledo State College of Medicine. He explained that an intellectual interaction of the colleges in the Toledo area is essential to the growth of the medical school and he invited auxiliary members to participate in this new exciting venture.

What was called the group's Medical Supplies Day (culminating months of work by its special committee) proved a gratifying success. Equipment and supplies literally poured into the Academy of Medicine via truck, van and station wagon. There was also a tremendous response from the pharmacists and dentists. Once everything was brought together, there began the staggering job of sorting and packing. And finally through the outstanding cooperation of local van and trucking firms, these treasured supplies found their way to World Medical Relief headquarters in Detroit. I'm told (at least verbally!) that orchids should be handed to Mrs. Henry Silverman and Mrs. Harold Poneman, cochairmen, and these members of their committee: Mrs. Hammond Chen, Mrs. Paul Ditmyer, Mrs. Harvey Muehlenbeck, Mrs. George Thraikill, Mrs. Warren Underhill and Mrs. David Wheeler.

Lucas County has had a busy time of it! "Health Career Day" was cosponsored by the auxiliary and the Academy of Medicine. There were 16 professional organizations represented with exhibits, literature and knowledgeable people to answer the questions of interested students. Mrs. Richard Alberry served as chairman.

Mrs. Van Epps

A resolution of commendation for Mrs. Herbert F. Van Epps, last year's state president, was presented at a recent meeting of her Tuscarawas Auxiliary at the home of Mrs. Efrain Padro. The commendation read in part that "it is timely and most proper that we pay tribute to the most distinguished member of our organization . . . her services were consistent, unselfish and farsighted . . . we, her fellow members who recognize her as a leader and a friend, express our deep appreciation of her valued contributions to the medical auxiliary and to the community . . ."

Mrs. E. L. Miller presided at the meeting and

reported that 164 pounds of drugs had been sent to World Medical Relief. Francis Hazard, guest speaker and director of the Tuscarawas County Academic Center of Kent State University, discussed the progress stage of the new Branch. He said that a program receiving much consideration is the nursing program toward an R. N. degree. Mrs. M. W. Everhard, Mrs. L. L. Appel and Mrs. M. R. Puterbough were assisting hostesses.

The Washington County Auxiliary sponsored a Future Nurses' Club tea at which a film "Girls in White" was presented. This tea is an annual event each fall and this time it was held at Marietta Memorial Hospital. Seventy-five seniors from St. Marys, Warren, and Marietta High Schools attended. Joseph Stubbs, hospital administrator, spoke to the students on "Nursing and the Function of a Hospital." Dr. Mary Whitacre discussed "Why Choose Nursing?" Preceding the tea, the auxiliary had its monthly meeting and luncheon in the hospital cafeteria.

Another Tribute

A Franklin County auxiliary member, Mrs. Rivington Fisher, was honored recently by being elected Woman of the Year by the Chi Omega Alumnae Chapter of Columbus. Mrs. Fisher was honored for "her accomplishments . . . which have contributed vastly to the civic, cultural, charitable, and educational development of the city of Columbus." Mrs. Fisher is my predecessor as state publicity chairman.

To auxiliary members everywhere: May this New Year of 1967 bless all of you with good health and much happiness.

Women Physicians Bestow Honor On Cincinnati Member

Dr. Esther C. Marting, Cincinnati radiologist, has been awarded the Elizabeth Blackwell Medal, highest honor of the American Medical Women's Association. It was presented to Dr. Marting last night (Nov. 4) at the AMWA's Inaugural Banquet in Washington, D. C.

During the banquet, Dr. Margaret J. Schneider, also of Cincinnati, passed on her gavel as president of the AMWA to Dr. Elizabeth A. McGrew of Chicago.

Dr. Marting is the 18th physician to receive the national honor, and the second from Cincinnati. In 1964 it was presented to Dr. Helena T. Ratterman of Cincinnati for her repeated organization of medical relief for flood victims. Dr. Marting received the medal for "unselfish and faithful service" for many years in assisting the advancement of women in medicine. She is the wife of Dr. Howard D. Fabing, Cincinnati neurologist. — *Cincinnati Post & Times Star*.

Tufts-New England Medical Center, in Boston, has announced a \$72.5 million, 15-year construction and expansion program.

HEW Recognizes 'Principles' . . .

Federal Agency, After Long Negotiations with the OSMA, Accepts 'Principles' as Assurance of Nondiscrimination

CAN the Federal government discriminate against a profession in enforcing nondiscrimination statutes?

"No," the Ohio State Medical Association emphatically declared in its 16-month successful fight against U. S. Department of Health, Education, and Welfare requirements that Ohio physicians sign nondiscrimination oaths before they could be reimbursed for their professional services to patients under Federally-assisted programs.

OSMA contended that the laws of the land apply equally to all citizens, and a regulation requiring a segment of the citizenry to sign a pledge to abide by a law was an act of discrimination against that segment.

OSMA further contended that such a regulation, in effect, placed its members in a category of "second-class citizens."

When the Ohio Department of Public Welfare, without prior consultation with OSMA, mailed pledge cards to Ohio physicians in July of 1965, the Association protested the action. OSMA offered, in order, several recommendations which would be acceptable to the profession. Each recommendation was accepted by the ODPW, but summarily rejected by HEW.

Direct Action

Following a nonproductive request to the American Medical Association for action, OSMA then took up the issue directly with HEW.

After obtaining from HEW's Commissioner of Welfare Administration written proof that the method of compliance with Title VI of the Civil Rights Act must have the approval of HEW, a letter stating that the Principles of Medical Ethics, to which all members of OSMA pledge their adherence, was more than adequate to cover the matter of nondiscrimination, was addressed to the commissioner as follows:

September 1, 1966

Ellen Winston, Ph. D.
Commissioner of Welfare Administration
U. S. Department of Health, Education, and Welfare
Washington, D. C. 20201

Dear Dr. Winston:

Thank you for your letter of August 25.

There is a definite conflict between what is stated

in your letter and what has transpired in our efforts over the past 13 months to resolve this question.

You definitely state in your letter of August 25 that the Department of Health, Education, and Welfare does not require that physicians sign pledges or statements that they have complied with Title VI.

On the other hand, we have, on three separate occasions, advanced proposals to the Ohio Department of Public Welfare that would resolve this issue, proposals that were readily accepted by the Ohio Department but summarily rejected by HEW.

For example, the Ohio Department enthusiastically accepted our proposal that, inasmuch as members of this Association must, to become and to continue to be members, pledge their adherence to the *Principles of Medical Ethics*, evidence of membership is evidence of nondiscrimination.

Reference is made, in particular, to three sections of these *Principles*, namely:

"Section 1. The principal objective of the medical profession is to render service to humanity with full respect for the dignity of man. Physicians should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion."

I would call to your attention the phrase "* * * with full respect for the dignity of man."

"Section 4. The medical profession should safeguard the public and itself against physicians deficient in moral character or professional competence. Physicians should observe all laws (emphasis added), uphold the dignity and honor of the profession and accept its self-imposed disciplines. They should expose, without hesitation, illegal or unethical conduct of fellow members of the profession."

I would call to your attention the wording, "Physicians should observe all laws, * * *" By pledging observance of all laws, such pledge would include Title VI, inasmuch as it is a part of a duly constituted law.

"Section 10. The honored ideals of the medical profession imply that the responsibilities of the physician extend not only to the individual, but also to society (emphasis added) where these responsibilities deserve his interest and participation in activities which have the purpose of improving the health and

the well-being of the individual and the community."

Res ipsa loquitur.

Why, then, Dr. Winston, does your Department refuse to accept the assurance of the Ohio Department of Public Welfare that a physician's pledge of adherence to the *Principles of Medical Ethics* as demonstrated by his membership in this Association is evidence that he does not practice discrimination?

Inasmuch as The Council of this Association has directed me to present a report on this situation at its meeting of September 9, 10, and 11, a reply to this letter prior to the meeting would be extremely helpful.

(Signed) Charles W. Edgar
Director of Public Relations
Ohio State Medical Association

The letter resulted in a telephone call from an HEW aide who stated that (1) *Principles of Medical Ethics* could not be accepted by HEW because of HEW's knowledge of discrimination in Southern States, and (2) HEW had no assurance that the *Principles* would be enforced in Ohio.

Asked if he knew of any discrimination in Ohio, the aide said he had no such knowledge. He then was informed that a letter stating that the *Principles* would be enforced was to be addressed to the Ohio Department of Public Welfare.

Following the OSMa's statement that the *Principles* would be applied, and a charge of discrimination handled under the same procedure as any other charge of violating the *Principles*, HEW accepted the Association's position.

As the result, physicians certified to the Ohio Department of Public Welfare as being OSMa members in good standing need not sign a nondiscrimination oath or use a stamped statement on their billing forms.

Physicians who are not members of OSMa must continue to comply with the requirement for a signed oath or use a nondiscrimination statement on their billing forms.

New Members . . .

Following are names of new members of the Ohio State Medical Association certified to the Headquarters Office during November. List shows name of physician, county, and city in which he is practicing, or temporary addresses for those taking graduate work:

Cuyahoga

Peter T. Cubberley, Cleveland
M. Weston Reynolds,
Cleveland

Lorain

Richard C. Wamsley, Oberlin

Lucas

J. Herbert Manton, Toledo

Summit

Genevieve A. Drews, Akron

Symposium on Cancer Therapy Scheduled in Youngstown

Symposium on Cancer Therapy, cosponsored by the Mahoning County Medical Society and the Mahoning County Chapter of the American Academy of General Practice, will be held on Sunday, January 29, at the Voyager Motor Inn, Youngstown.

The following outstanding program for physicians and wives has been made possible through a grant from Lederle Laboratories:

Current Trends in Therapeutic Cancer Research—Emil J. Freireich, M. D., Chief, Research Hematology, The University of Texas, M. D. Anderson Hospital and Tumor Institute, Houston.

Potential of the Laser Beam in the Treatment of Cancer—Paul E. McGuff, M. D., Ph. D., New Orleans.

Questions and Answers.

Luncheon for physicians and wives.

Emotional Problems of Children—Beverly T. Mead, M. D., Professor and Chairman, Departments of Psychiatry and Neurology, Creighton University School of Medicine, Omaha.

Endocrine Abnormalities in Cancer—T. S. Danowski, M. D., Professor of Medicine, University of Pittsburgh School of Medicine, Pittsburgh.

Practical Approaches to the Therapy of Cancer—Robert T. Breckenridge, M. D., Department of Medicine, Western Reserve University, Lakeside Hospital, Cleveland.

Questions and Answers.

Registration will begin at 9:00 A. M. The program will open with a welcome by Dr. H. J. Reese, president of the Medical Society and by Dr. F. W. Dunlea, president of the Mahoning Chapter, AAGP.

Moderator for the morning session is Dr. S. W. Ondash, and for the afternoon session, Dr. W. D. Loesser. Chairman for the luncheon session is Dr. E. T. Saadi.

A reception will be held at 4:00 P. M., following the final question and answer period.

All physicians and their wives are urged to attend. There will be no charge for any of the sessions, luncheon, or reception. Reservations may be made at the Mahoning County Medical Society office. The program has been approved for five hours of continuation study credit by the American Academy of General Practice.

The *S. S. Hope* will undertake a ten-month mission to Colombia next year. According to Dr. William B. Walsh, President of Project Hope, the famed white hospital ship will sail February 7 for the port of Cartagena, on Colombia's Caribbean coast, arriving there February 17.

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National Medicolegal Symposium To Be Held in Miami Beach

Miami Beach has been selected as the site for the 1967 National Medicolegal Symposium jointly sponsored by the American Medical Association and the American Bar Association.

To be held at the Fontainebleau Hotel March 9-11, the meeting affords an opportunity for lawyers and doctors to discuss matters of common interest and to seek solutions for interprofessional differences.

Registration fee, which includes a reception and a copy of the proceedings, is \$30.00.

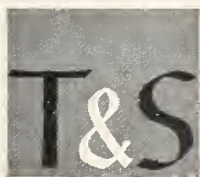
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The OHIO STATE MEDICAL Journal



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Let's get
down to earth
about
diuretics

Editorial:

Cardiopulmonary Resuscitation

One of the most dramatic developments in medical therapy for the past quarter century has been the technique of cardiopulmonary resuscitation (C.P.R.), first published as a coordinated technique in the medical literature in 1960. It is a remarkable phenomenon on several scores: external cardiac massage was the contribution of a team consisting of a surgeon, a retired electrical engineering professor, and a master of science in engineering. Although announced through ethical medical channels, it was first accepted with evangelical zeal by laypeople rather than by the medical profession, and only in the past two years has it reached a stage of adequate implementation in medical institutions. It was a product of medical center research sponsored by the electric utility industry, but for meaningful results it must be taught to every doctor, every nurse, every hospital attendant as well as rescue personnel. It is ironic that after a decade of controversy regarding the statistics of a possible clinical benefit for anticoagulation in acute myocardial infarction this entirely new approach appeared and offered an opportunity for substantially reducing the hospital mortality for myocardial infarction.

See Symposium pages 191-194.

Success in hospital and community programs of cardiopulmonary resuscitation is dependent upon thorough training and periodic retraining of all personnel. This must be done at the "grass-roots" level; that is, by competent instructors in each hospital and community with continued in-service refresher courses.

A pioneering course for instructors who could carry on such local instruction in cardiac resuscitation was initiated in 1950, at Western Reserve University in Cleveland, Ohio, by Doctors Claude Beck and David Leighninger and now meets nine times a year sponsored by the Heart Association of Northeastern Ohio. These two-day courses are for physicians, nurses, dentists, and other qualified paramedical personnel, and application may be made by writing Mr. Lawrence Stadler, Heart Association of Northeastern Ohio, Inc., 1689 East 115th Street, Cleveland, Ohio 44106.

The American Heart Association has been honored to be one of the leaders in this field, and has prepared instructional booklets, slides, films, and posters which are basic instructional material. The Heart Association led several other professional groups in issuing the first policy statement in 1962, which called C.P.R. a *medical* procedure of great importance. In

(Continued on next Page)

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1965, the Heart Association issued a second policy statement reclassifying C.P.R. as an *emergency* procedure which should be applied "after the occurrence of cardiac arrest by well-trained physicians, nurses, and members of the allied health professions and rescue squads." This statement was also signed by the American National Red Cross, Industrial Medical Association, and U. S. Public Health Service. The officially recommended procedure, largely as outlined by the Heart Association for the past two years, was adopted as of October 24, 1966, by the Ad Hoc Committee on Cardio-Pulmonary Resuscitation of the Division of Medical Sciences National Academy of Sciences — National Research Council and appeared in the *Journal of the American Medical Association* of that date.

The Ohio State Heart Association fervently believes that such training should be carried on by competent local instructors in every hospital and community in the state. To enable the training of such instructors it is sponsoring, with the Ohio Department of Health Division of Chronic Diseases, one-day training sessions for instructors in each of the eight metropolitan centers in this state. Information about these seminars as well as booklets, posters, slides, films, training mannikins, and other aids may be obtained from your local Heart Association.

GEORGE MORRICE, M.D.

President, Ohio State Heart Association

Trademark of Drug Manufacturer Protected by Injunction

The United States District Court for New Jersey has permanently enjoined American Vitamin Products Inc., of Newark, New Jersey, from using certain trademarks which are similar to those of Eli Lilly and Company, Indianapolis pharmaceutical manufacturer.

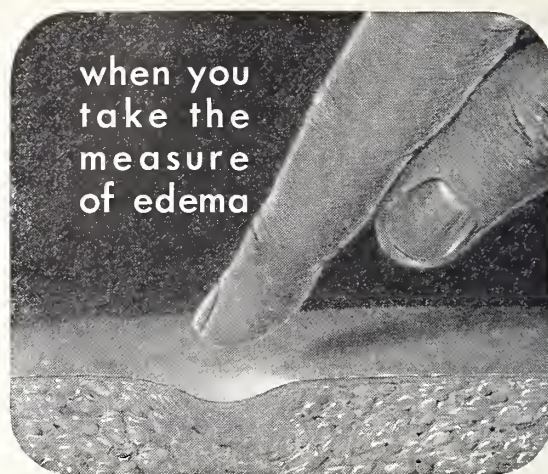
The Indiana company filed the trademark infringement suit against American Vitamin Products and E. Joseph Edell and Arthur Edell.

The Lilly company charged that the New Jersey firm was offering for sale products with names closely imitating four Lilly trademarks.

The defendants signed a consent decree which was entered into the court records before Judge R. J. Wortendyke.

Research Project Grant

The National Institutes of Health has awarded a one-year \$60,000 contract to Norman L. Somerson, Ph. D., associate professor of medical microbiology in the Ohio State University College of Medicine, for basic research aimed at development of a vaccine effective against certain types of pneumonia, colds, and respiratory diseases, especially the mycoplasmas. Research for the project will be conducted at Columbus Children's Hospital.



... introduce your patient to

aQUATAG®
(BENZTHIAZIDE)

AQUATAG (Benzthiazide) is a potent, orally active, nonmercurial, diuretic agent. It is effective orally in producing diuresis in edema states, where it is therapeutically comparable to mercurials given parenterally. AQUATAG (Benzthiazide) is mildly antihypertensive in its own right and enhances the action of other antihypertensive drugs when used in combination.

DIURETIC ACTION: Clinically, the oral administration of AQUATAG (benzthiazide) results in diuretic activity within two hours with maximal natriuretic, chloruretic, and diuretic effects occurring during the fourth, fifth and sixth hours. Maintenance of response continues for approximately 12 to 18 hours. Acidosis is an unlikely complication since therapeutic doses of AQUATAG (benzthiazide) do not appreciably increase bicarbonate excretion. Edematous patients receiving 50 mg. of AQUATAG (benzthiazide) daily for five days developed a maximal increase in the rate of sodium excretion on the first day, and maintained this high rate until depletion of excessive body stores of sodium.

In congestive heart-failure patients, AQUATAG (benzthiazide) produced the same weight loss, during a 48-hour treatment period as did a maximally effective dose of hydrochlorothiazide.

DOSAGE: Diuresis, initially 50 to 200 mg.; maintenance 25 to 150 mg., daily. Hypertension 50 to 100 mg. initially, adjusted to 50 mg. t.i.d. or downward to minimal effective dosage level.

WARNINGS: Use with caution in the presence of renal disease as azotemia may be precipitated or increased. In patients with advanced hepatic disease, electrolyte imbalance may result in hepatic coma. Dosage of coadministered antihypertensive agents should be reduced by at least 50%. In cases of suspected electrolyte imbalance, serum electrolyte determinations should be performed and imbalance, if any, corrected. Stenosis or ulcer of small intestine have been reported with coated potassium formulas, and surgery has been required and deaths have occurred. Based on surveys of both United States and foreign physicians, incidence of these lesions is low and a causal relationship in man has not been definitely established. Until further experience has been obtained, the use of the drug in pregnant patients should be weighed against possible hazards to the fetus.

CONTRAINDICATIONS: AQUATAG (benzthiazide) is contraindicated in progressive renal disease or dysfunction including increasing oliguria and azotemia. Continued administration of this drug is contraindicated in patients who show no response to its diuretic or antihypertensive properties. Severe hepatic disease is a relative contraindication. (See "Warnings" above.)

PRECAUTIONS AND SIDE EFFECTS: Electrolyte imbalance with hypokalemia (digitalis toxicity may be precipitated), hypochloremic alkalosis and hyponatremia may occur. Patients with cirrhosis should be observed for impending hepatic coma and hypokalemia. Other reactions may include blood dyscrasias, hyperuricemia and gout, nausea, jaundice, anorexia, vomiting, diarrhea, dizziness, paresthesia, photosensitivity and headache. Hepatic tetor, tremor, confusion and drowsiness are signs of impending pre coma and coma in patients with cirrhosis. Insulin requirements may be altered in diabetes. AQUATAG (benzthiazide) should be used with caution post-operatively as hypokalemia is not uncommon. Potassium supplementation may be advisable pre- and post-operatively. There have been occasional reports of thrombocytopenia, leukopenia, agranulocytosis, aplastic anemia and precipitation of acute pancreatitis or jaundice.

Before prescribing or administering, read the package insert or tile card available on request.

Available as 25 or 50 mg. scored tablets.

Request clinical samples and literature on your letterhead.



**S.J. TUTAG
& COMPANY**

Detroit, Michigan 48234

Interesting Statistics Presented On Death Rates During 1966

The death rate among Americans rose slightly in 1966, according to the Metropolitan Life Insurance Company. The past year's national death rate is estimated at 9.7 per 1,000 population by the company's statisticians, compared with 9.4 in 1965. This was the 19th successive year to register a rate below 10 per 1,000 population.

Increased mortality was the trend for most of the leading causes of death, Metropolitan statisticians report.

Mortality from pneumonia and influenza and from other respiratory diseases, including emphysema, was up about 10 per cent over 1965. Although this reflected outbreaks of influenza in the spring of 1966, it was also part of a long-term trend. About 35 persons per 100,000 died of pneumonia and influenza this past year, registering the highest death rate from this cause in the last five years.

A slight increase was recorded in the death rate from diseases of the heart and arteries, which currently account for a little more than half of all deaths in the United States. Arteriosclerotic heart disease, mainly coronary, showed a small increase of about 4 per cent.

Cancer, second only to heart disease as a cause of death, showed virtually no change in mortality from the year before. However, this lack of change was the result of increases in the cancer death rate of some sites that counterbalanced the decreases in others. The rise was most notable for lung cancer, which continued its long-term upward trend with an estimated 5 per cent increase in the 1966 death rate over the previous year.

Death rates for diabetes and cirrhosis of the liver also showed small increases over 1965.

Data available at this time indicate that motor vehicle fatalities were up about 9 per cent in 1966. For all types of accidental injuries combined the fat-

ality rate is likely to be about 5 per cent higher, say Metropolitan's statisticians.

Infant mortality, which in 1965 and 1964 had set an all-time low of 25 deaths per 1,000 live births, further declined to a rate of 24 in 1966.

Progress in Acid-Base Research Reported by OSU Team

Three researchers from the Ohio State University College of Medicine and Columbus Children's Hospital have succeeded in measuring the pH of mitochondria for the first time, using a newly devised method involving radioactive isotopes, according to a report from the College.

The research was done at Children's Hospital's Clinical Study Center by Somasundaram Addanki, Ph. D., a biochemist and principal investigator; Juan F. Sotos, M. D., Center director, and Dallas Cahill, a hospital research assistant. Dr. Addanki is assistant professor in the Departments of Pediatrics and Physiological Chemistry, and Dr. Sotos is associate professor of pediatrics at Ohio State.

The new method gives scientists a tool for studying acid-base regulation of cells as well as mitochondria. The research team believes it paves the way for study and possible treatment of several acid-base disorders.

American EEG Society Offers Course in Philadelphia

A continuation course in "Clinical Electroencephalography" will be conducted on June 5-7 in Philadelphia, Pa. This is the second course sponsored by the American EEG Society (aided by a grant from the Bureau of State Services, USPHS) and is designed for physicians who have had little or no formal EEG training. Inquiries about further details of the course and registration procedure should be addressed to Dr. Donald W. Klass, EEG Course Director, Mayo Clinic, Rochester, Minnesota.



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**Crista
galli**

**Os
nasale**

Lamina cribrosa ossis ethmoidalis

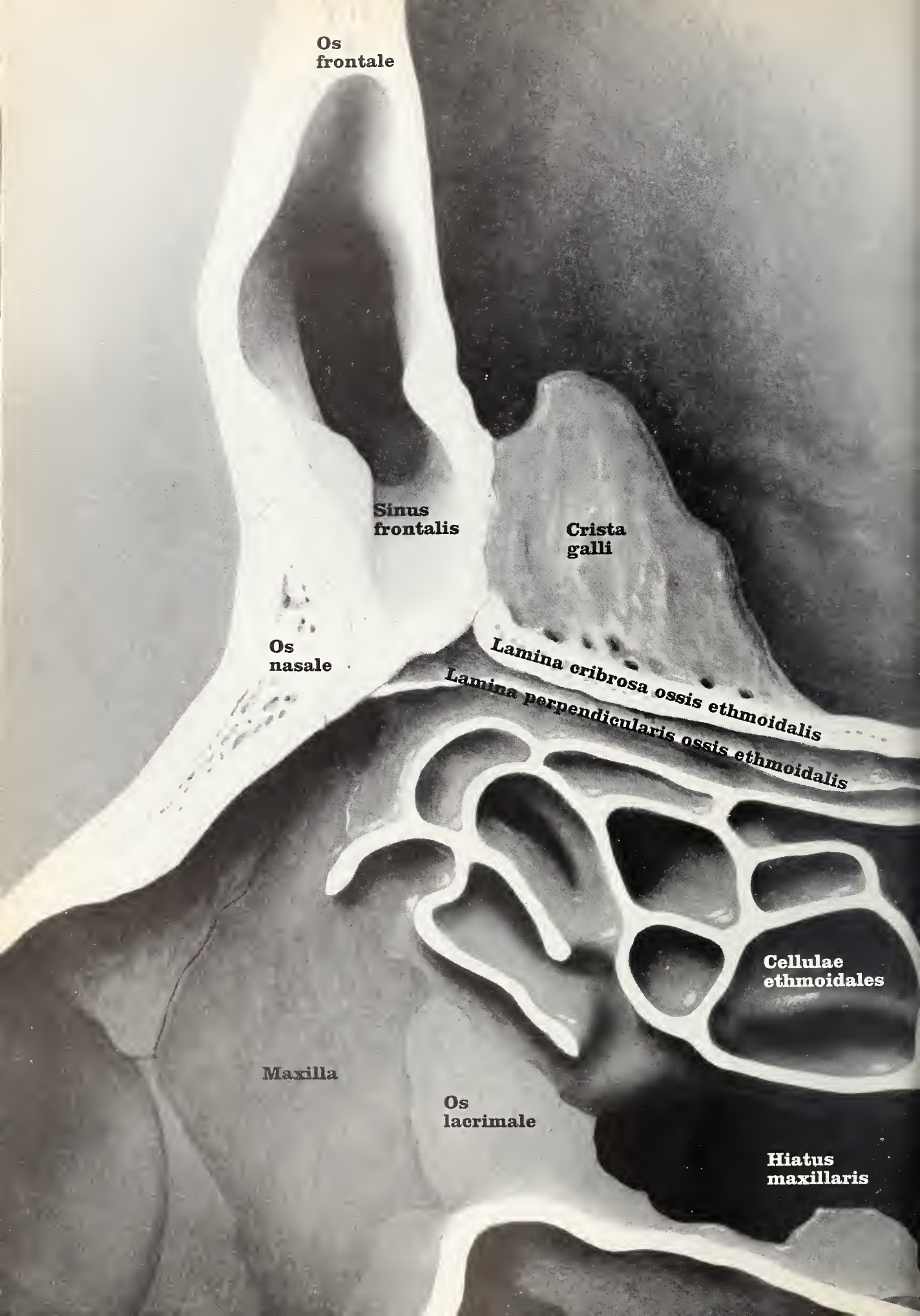
Lamina perpendicularis ossis ethmoidalis

**Cellulae
ethmoidales**

Maxilla

**Os
lacrimale**

**Hiatus
maxillaris**



You can't set her free. But you can help her feel less anxious.

You know this woman.

She's anxious, tense, irritable. She's felt this way for months.

Beset by the seemingly insurmountable problems of raising a young family, and confined to the home most of the time, her symptoms reflect a sense of inadequacy and isolation. Your reassurance and guidance may have helped some, but not enough.

SERAX (oxazepam) cannot change her environment, of course. But it can help relieve anxiety, tension, agitation and irritability, thus strengthening her ability to cope with day-to-day problems. Eventually—as she regains confidence and composure—your counsel may be all the support she needs.

Indicated in anxiety, tension, agitation, irritability, and anxiety associated with depression.

May be used in a broad range of patients, generally with considerable dosage flexibility.

Contraindications: History of previous hypersensitivity to oxazepam. Oxazepam is not indicated in psychoses.

Precautions: Hypotensive reactions are rare, but use with caution where complications could ensue from a fall in blood pressure, especially in the elderly. One patient exhibiting drug dependency by taking a chronic overdose developed upon cessation questionable withdrawal symptoms. Carefully supervise dose and amounts prescribed, especially for patients prone to overdose; excessive prolonged use in susceptible patients (alcoholics, ex-addicts, etc.) may result in dependence or habituation. Reduce dosage gradually after prolonged excessive dosage to avoid possible epileptiform seizures. Caution patients against driving or operating machinery until absence of drowsiness or dizziness is ascertained. Warn patients of possible reduction in alcohol tolerance. Safety for use in pregnancy has not been established.

Not indicated in children under 6 years; absolute dosage for 6 to 12 year-olds not established.

Side Effects: Therapy-interrupting side effects are rare. Transient mild drowsiness is common initially; if persistent, reduce dosage. Dizziness, vertigo and headache have also occurred infrequently; syncope, rarely. Mild paradoxical reactions (excitement, stimulation of affect) are reported in psychiatric patients. Minor diffuse rashes (morbilliform, urticarial and maculopapular) are rare. Nausea, lethargy, edema, slurred speech, tremor and altered libido are rare and generally controllable by dosage reduction. Although rare, leukopenia and hepatic dysfunction including jaundice have been reported during therapy. Periodic blood counts and liver function tests are advised. Ataxia, reported rarely, does not appear related to dose or age.

These side reactions, noted with related compounds, are not yet reported: paradoxical excitation with severe rage reactions, hallucinations, menstrual irregularities, change in EEG pattern, blood dyscrasias (including agranulocytosis), blurred vision, diplopia, incontinence, stupor, disorientation, fever, euphoria and dysmetria.

Availability: Capsules of 10, 15 and 30 mg. oxazepam.

To help you relieve anxiety and tension

Serax[®] (oxazepam)



Wyeth Laboratories
Philadelphia, Pa.

New Members . . .

Following are names of new members of the Ohio State Medical Association certified to the Headquarters Office during December. List shows name of physician, county, and city in which he is practicing or temporary addresses for those taking graduate work.

Cuyahoga

Jack W. Jaffe, Cleveland
Malcolm MacKenzie,
Cleveland
Randall B. K. Radcliffe,
Cleveland

Lucas

James L. Philip, Toledo

Montgomery

Gaston Bouquett, Dayton

Stark

James A. Niffenegger,
Canton
H. Necdet Topcuoglu, Canton
Frank J. Weinstock, Canton
Ali R. Yaghooti, Canton

Medical School Enrollments Continue Upward Trend

American medical education has undergone significant changes in the past year, and more changes are on the way.

This is the picture presented by the American Medical Association's Council on Medical Education in its 66th annual report, which appears in the November 21 *Journal of the AMA*.

The massive report shows these things:

Total enrollment is at a new high in U. S. medical schools. Total enrollment is 32,835, up from last year's 32,428.

Sixteen new medical schools are continuing their development programs. The new schools are expected to be graduating an additional 1,062 medical students annually by the mid-1970s.

By 1975, 10,000 U. S. medical students will be graduated annually, according to medical school deans' estimates.

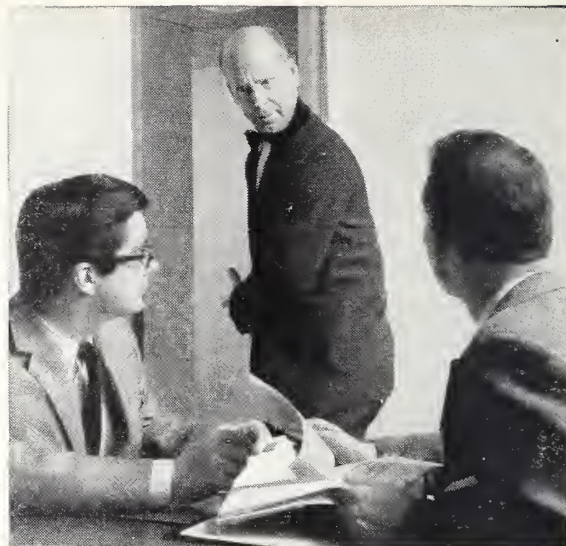
The total graduated from U. S. medical schools during the past year is 7,574, 163 more than the preceding year, and an all time high.

The total of internship and residency positions offered in U. S. hospitals (54,866) has increased almost two per cent in the past year.

There has been a 47 per cent increase this year in hospitals with a major medical school affiliation. A total of 275 hospitals now have such an affiliation.

Several major studies of medical education have been published recently. Many factors outlined in these reports foretell major changes in the future of medical education, the report said. Major reports summarized include the reports of the AMA-Appointed Citizens Commission on Graduate Medical Education, the AMA Ad Hoc Committee on Education for Family Practice, the National Commission on Community Health Services, the report to the Association of American Medical Colleges by Lowell T. Coggeshall, M. D., and the reports of the Endicott House Summer Study on Medical Education and the

(Continued on Page 165)



He leaves to make an urgent call But doesn't use the phone at all

Parepectolin for quick relief of acute diarrhea
...soothes colicky pain with paregoric
...consolidates fluid stools with pectin
...adsorbs irritants with kaolin, and protects
intestinal mucosa

Whether it's a 24-hour "bug", a food problem, or simply nervousness and anxiety, Parepectolin will bring the diarrhea under control until etiology can be determined. In some cases, Parepectolin may be all the therapy necessary.



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Each fluid ounce of creamy white suspension contains:
Paregoric (equivalent) (1.0 dram) 3.7 ml.
Contains opium (¼ grain) 15 mg. per fluid
ounce.
warning: may be habit forming
Pectin (2½ grains) 162 mg.
Kaolin (specially purified) . . . (85 grains) 5.5 Gm.
(alcohol 0.69%)
Usual Adult Dose: One or two tablespoonfuls three
times daily.



WILLIAM H. RORER, INC.
Fort Washington, Pa.

(Continued from Page 160)

Fort Lauderdale Conference on Medical Services and Medical Education.

Special studies by the AMA Council on Medical Education, published in the report for the first time, show that some states contribute more medical graduates than they get back as trained physicians, notably New York, Pennsylvania, Illinois, and New Jersey. On the other hand, some states, particularly California, Louisiana, Missouri, and North Carolina, annually receive greater numbers of trained physicians than their contributions of medical graduates.

Another special study of the Council, based on statistics compiled by the AMA, shows that foreign medical graduates make up 29 per cent of trainees now enrolled in U. S. graduate medical education.

As of September 1, 1965, there were 47,082 U. S., Canadian and foreign medical graduates in graduate medical education leading toward licensure, general or specialty practice, or specialty board certification.

Of this total, 9,670 (21 per cent) were interns, 31,687 (67 per cent) were residents, and 5,725 (12 per cent) were in other types of training.

The Division of Postgraduate Education, University of Florida College of Medicine, Gainesville, Florida, has announced a course on "Cardiac Embryology and Pathology of Congenital Heart Disease," on March 2-4.

Ohioan Among Physicians Serving in Volunteer Vietnam Program

An Ohio physician, Dr. Robert E. Cooke, of Harrison, was recently reported serving on a team in Vietnam under the American Medical Association Volunteer Physicians for Vietnam program. The program provides medical care to the civilian population of South Vietnam through the volunteer services of U. S. Physicians.

Volunteer physicians serve a 60-day tour of duty. Their services are entirely unpaid. The United States Agency for International Development pays travel expenses and a \$10 a day expense allowance.

A serious shortage of native physicians exists in South Vietnam. Of approximately 1,000 Vietnamese physicians, nearly 900 are in the armed forces, leaving only about 100 to care for the health needs of 16 million people.

Reserve Research Team Applies Ultrasonics to Eye Surgery

A research team at Western Reserve University School of Medicine recently was reported beginning clinical trials on an ultrasonic method of replacing retinas, after extensive animal experimentation in this technique. A heat source such as the laser beam is being used for welding until the method of welding with ultrasound is perfected.

For the treatment of
apathy
irritability
forgetfulness
confusion
in the aging patient

EACH CEREBRO-NICIN CAPSULE CONTAINS:

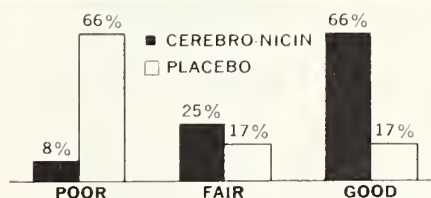
Pentamethylene Tetrazole	100 mg.
Nicotinic Acid	100 mg.
Ascorbic Acid	100 mg.
Thiamine HCl	25 mg.
L-Glutamic Acid	50 mg.
Niacinamide	5 mg.
Riboflavin	2 mg.
Pyridoxine	2 mg.

DOSAGE: One capsule t.i.d. or as prescribed by physician.
AVAILABLE: Bottles of 100, 500, 1000 capsules.
Also elixir pint bottles.

CONTRAINDICATIONS: There are no known contraindications to Pentamethylene Tetrazole although caution should be exercised when treating patients with a low convulsive threshold. Most persons experience a flushing or tingling sensation after taking a higher potency niacin-containing compound. As a secondary reaction some will complain of nausea and other sensations of discomfort. This reaction is transient and is rarely a cause of discontinuance of the drug if the patient is forewarned to expect the reaction. Federal law prohibits dispensing without a prescription.

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A GENTLE CEREBRAL STIMULANT AND VASODILATOR



CEREBRO-NICIN® New double-blind study* shows how effectively senility can be forestalled. Four times as many aging patients showed striking improvement.

*A Double-Blind Study of Cerebro-Nicin, Therapy for the Geriatric Patient, R. Goldberg, Jnl. of the Amer. Ger. Soc., June, 1964.

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One 'Ornade' Spansule Capsule works all day (or all night) to make your patient with a cold a lot more comfortable.

'Ornade', the unique oral nasal decongestant with a drying agent, a decongestant and an antihistamine in the ideal dosage form

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brand of sustained release capsules

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Each capsule contains 8 mg. of Teldrin® (brand of chlorpheniramine maleate), 50 mg. of phenylpropanolamine hydrochloride, and 2.5 mg. of isopropamide, as the iodide.

The following is a brief precautionary statement. Before prescribing, the physician should be familiar with the complete prescribing information in SK&F literature or PDR. **Contraindications:** Patients with glaucoma, prostatic hypertrophy, stenosing peptic ulcer, pyloroduodenal obstruction, or bladder neck obstruction. **Precautions:** Use with caution in the presence of hypertension, hyperthyroidism, or coronary artery disease; and, in patients who may operate vehicles or machinery, warn of possible drowsiness. **Note:** Since the iodine in isopropamide iodide may alter PBI test results and will suppress ¹³¹I uptake, it is suggested that 'Ornade' be discontinued one week before these tests. **Side effects:** Drowsiness; excessive dryness of nose, throat, or mouth; nervousness; or insomnia may occur rarely, but are usually mild and transitory. Other known possible side effects of the individual ingredients are: nausea, vomiting, diarrhea, rash, dizziness, fatigue, tightness of chest, abdominal pain, irritability, tachycardia, headache, and difficulty in urination.

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Nutritional reinforcement for those who can't
—or won't—eat properly...balanced amounts of
estrogen and androgen to counteract declining
gonadal hormone secretion and its sequelae of
premature degenerative changes...mild
antidepressant for a gentle "mood" uplift...

The estrogen component in MEDIATRIC is PREMARIN[®] (conjugated estrogens—equine), the natural estrogen most widely prescribed for its superior physiologic and metabolic benefits.

MEDIATRIC also provides *nutritional reinforcement—blood-building factors and vitamin supplementation*. It contributes a gentle "mood" uplift through methamphetamine HCl.

Three different dosage forms—Liquid, Tablets, and Capsules—offer convenience and variety.

MEDIATRIC Liquid

Each 15 cc. (3 teaspoonfuls) contains:

*Conjugated estrogens—equine (Premarin [®])	0.25 mg.
Methyltestosterone	2.5 mg.
Thiamine HCl	5.0 mg.
Cyanocobalamin	1.5 mcg.
Methamphetamine HCl	1.0 mg.

Contains 15% alcohol

MEDIATRIC Tablets and Capsules

Each MEDIATRIC Tablet or Capsule contains:

*Conjugated estrogens—equine (Premarin [®])	0.25 mg.
Methyltestosterone	2.5 mg.
Ascorbic acid	100.0 mg.
Cyanocobalamin	2.5 mcg.
Intrinsic factor concentrate	8.0 mg.
Thiamine mononitrate	10.0 mg.
Riboflavin	5.0 mg.
Niacinamide	50.0 mg.
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Calc. pantothenate	20.0 mg.
Ferrous sulfate exsic.	30.0 mg.
Methamphetamine HCl	1.0 mg.

*Orally active, water-soluble conjugated estrogens derived from pregnant mares' urine and standardized in terms of the weight of active, water-soluble estrogen content.

MEDIATRIC helps keep the older patient alert and active; helps relieve general malaise, easy fatigability, vague pains in the bones and joints, loss of appetite, and lack of interest usually associated with declining gonadal hormone secretion.

CONTRAINDICATION: Carcinoma of the prostate, due to methyltestosterone component.

WARNING: Some patients with pernicious anemia may not respond to treatment with the Tablets or Capsules, nor is cessation of response predictable. Periodic examinations and laboratory studies of pernicious anemia patients are essential and recommended.

SIDE EFFECTS: In addition to withdrawal bleeding, breast tenderness or hirsutism may occur.

SUGGESTED DOSAGES: *Male and female:* 3 teaspoonfuls of Liquid, 1 Tablet, or 1 Capsule, daily or as required.

In the female: To avoid continuous stimulation of breast and uterus, cyclic therapy is recommended (3 week regimen with 1 week rest period—Withdrawal bleeding may occur during this 1 week rest period).

In the male: A careful check should be made on the status of the prostate gland when therapy is given for protracted intervals.

SUPPLIED: No. 910 — MEDIATRIC Liquid, in bottles of 16 fluidounces and 1 gallon. No. 752 — MEDIATRIC Tablets, in bottles of 100 and 1,000. No. 252 — MEDIATRIC Capsules, in bottles of 30, 100, and 1,000.



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Developments in Immunization . . .

Ohio Physician Reports on Developments in Research Presented During Meeting at USPHS Communicable Disease Center in Atlanta

A COMPREHENSIVE PROGRAM on recent developments in immunizations was presented by a faculty of experts in this field during a recent meeting at the U. S. Public Health Service Communicable Disease Center in Atlanta, Ga. Dr. Tennyson Williams, Delaware, member of the OSMA Committee on Environmental and Public Health, attended this meeting as an official representative of the Association. Following is a summary by Dr. Williams of developments reported during the program:

1. D.T.P. — Titer studies done on service men have shown tetanus antibodies remaining at adequate levels for up to 20 years. The small amount of diphtheria in adult type T.D. has been shown to actually stimulate adequate diphtheria immunization when given as the primary immunization, and is, therefore, recommended for primary adult immunization with three injections, the first two one month apart, the third one year later, then routine boosters every ten years.

Adult type T.D. is recommended instead of D.T.P. for primary immunization or boosters after age 8 and also at ten year booster intervals. When using adult T.D., Shick testing is not necessary as undue reactions will not occur. Tetanus booster at time of injury is recommended if the last booster has been longer than one year ago. Primary immunization under age 8 should consist of three D.T.P.'s at monthly intervals; next, one year later; the next, two years later, and when started in infancy, the next at school entry with D.T.P. or adult type T.D.

2. Smallpox — Recent articles pointing to smallpox vaccination were recognized but not judged to be sufficient reasons for dropping immunization routines providing contraindications were carefully observed, these being

1. Eczema or other forms of chronic dermatitis in the individual or any household contact.
2. Pregnancy.
3. Patients taking immunosuppressive therapy.
4. Patients with leukemia, lymphoma, or other reticuloendothelial malignancies, or dysgamma globulinemia.

Recommendations are for primary vaccination between six and eighteen months of age and repeated every five years. Effective vaccination within three years is required for foreign travel.

All European epidemics have involved many cases contracted in the hospital since smallpox is so rare

that diagnosis is delayed. Because of this, smallpox boosters every year for hospital personnel is recommended after projects conducted to get all personnel up to date.

3. Measles Vaccine — The use of measles vaccine was highly recommended. While aggressive programs could "eradicate measles in the next six months," it was accepted that a program of immunizing infants at age one year, and other preschoolers on entry to school was considered practical at this time. The development of community programs similar to the Sabin programs were deemed unnecessary. The use of killed vaccine was discouraged. Comparable results are obtained from the use of Edmonston strain with gamma globulin (though a higher rate of reaction can be expected) or Schwarz Strain, so there was no preference shown for any specific live attenuated vaccine. Contraindications included:

1. Leukemia, lymphoma, or other generalized malignancies.
2. Patients receiving immunosuppressive therapy.
3. Pregnancy.
4. Allergy to vaccine components (egg, protein, etc.).
5. Defer for six weeks to six months after immune globulin.
6. Active tuberculosis (for this reason, well baby routines should incorporate a Tine Test at nine months of age before the measles vaccine at 12 months).
7. Severe febrile illnesses.
8. Do not give at the same time other live antigens are given.

4. Polio — Oral vaccines were favored over the Salk vaccine. The recommended procedure was the use of Sabin trivalent oral vaccine at the time of the first and third D.T.P., repeated one year later, and again at school entry. It was suggested that adults entering foreign travel be given three doses of trivalent oral vaccine, the first two, two months apart and the third, one year later, regardless of whether or not they had had the Salk vaccine. It was felt all under age 18 should be given the vaccine, and adults over age 18 only if entering foreign travel or the Armed Services if going to endemic areas. The trivalent was not chosen because of any superiority to the single strain oral vaccine, but because it was felt to be less cumbersome in its application to schedules of overall vaccine programs.



For people who eat more than one meal a day

A PLEGINE (Phendimetrazine bitartrate) tablet taken an hour before each meal affords peak activity at mealtime, when it is needed most. Reminds patients to eat according to your prescribed diet plan.

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BRAND OF
Phendimetrazine bitartrate
provides peak appetite suppression when it's needed most

Indications: Recommended in the management of excessive appetite leading to obesity.

Cautions and Contraindications: No adverse effects on blood pressure, heart rate, and respiration have been reported. However, as is true for all medications of this type, PLEGINE (Phendimetrazine bitartrate) is not recommended for patients with coronary disease, severe hypertension, or thyrotoxicosis, and should be used with caution in highly nervous or agitated individuals.

Side Effects: There have been occasional reports of insomnia and nervousness. Rare instances of mouth dryness, nausea, blurring of vision, dizziness, constipation, and stomach pain have been noted.



AYERST LABORATORIES New York, N.Y. 10017 • Montreal, Canada

Research and Development Funds Are Still on the Increase

Total research and development (R&D) expenditures in the United States are expected to reach \$23.8 billion in 1967. This is an increase of \$500 million over the previous year, according to the annual R & D forecast by the Columbus Laboratories of Battelle Memorial Institute.

The projected 2.2 per cent rise over 1966 R & D spending is the lowest percentage increase in the 13-year period for which national survey data are available, and is also the smallest absolute dollar increase in expenditure since 1955.

Significantly, 80 percent of the predicted increase will come from funds provided by industry, universities, and nonprofit institutions, marking the first time in a decade that federal funds have not been the dominant factor in the R & D growth trend. Indicative of its continuing investment in research and development, industry in 1967 is expected to increase expenditures for R & D by about \$340 million—approximately two-thirds of the predicted total increase.

The annual forecast, prepared by Battelle-Columbus economists Ralph L. Craig, Joseph W. Duncan, and Leonard L. Lederman, indicates a leveling in federal

R & D expenditures, with prospective cutbacks during the latter half of 1967.

Breaking down the total expenditure estimate for 1967 by source of funds, the Battelle forecast predicts that federal government spending will total approximately \$16.2 billion; industry, about \$6.8 billion; colleges and universities, about \$480 million; and other nonprofit institutions, \$326 million.

Federal R & D expenditures in 1967 are expected to be \$100 million more than in 1966. This represents an increase of 0.6 percent.

The forecast notes that the recent slowdown in federal expenditures for research and development is believed to be a temporary transition. A fundamental factor causing the slowdown is the current imbalance in the national economy and the resulting pressure upon the federal budget.

Lectures in Radiology

On Saturday and Sunday, April 15 and 16, 1967, Dr. Richard H. Marshak, attending radiologist, Mt. Sinai Hospital, New York City, will deliver the nineteenth annual Joseph and Samuel Freedman Lectures in Diagnostic Radiology at the University of Cincinnati College of Medicine. Radiologists desiring to attend are requested to write Dr. Benjamin Felson, Department of Radiology, Cincinnati General Hospital, for further details.


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Health Officers of Cincinnati, Ohio And the Problems of Their Day

1900 to 1960

KENNETH I. E. MACLEOD, M.D., M.P.H.*

PART VIII

(Continued from January Issue)

Immunization Against Diphtheria

IN THE ISSUE for June 20, 1930 (CINCINNATI'S HEALTH, Vol. III, No. 1) mention is made of a campaign "under the auspices of the Academy of Medicine" to be launched on June 23 to banish diphtheria from Cincinnati. "Last year 35,000 children were immunized with the toxin-antitoxin mixture but we still have 30,000 children in the city who are susceptible . . ."

Heart Clinic

The outstanding heart clinic of Greater Cincinnati has been developed at the health center. This clinic is flourishing under the auspices of the Public Health Federation. Until January 15, 1929 two half-time dentists were employed in the adult dental clinic. Since that time one dentist has given two-thirds of his time to the work with better results. The infant and prenatal clinic grew during the year—1,098 cases; Negro attendance was 47 per cent. The bulk, however, of infant welfare work in Cincinnati is carried on by the Babies Milk Fund Association supported by the Community Chest.

The Perfect Food

The issue (Vol. III, No. 3) dated November 20, 1930 is almost entirely devoted to a discussion of the department's milk program, and the advantages of milk as "the most nearly perfect food . . ."

White House Conference

But there is also a report on the White House Conference on Child Health and Protection called by President Hoover, and a report on "a study of shop sanitation and methods" in cigar factories.

The trend in diphtheria incidence and death rates is given in Table 1.

U. S. Chamber of Commerce Competition

The issue for December 1, 1932 (Vol. V, No. 1) notes that

Cincinnati merited second place among the cities of its population class in the 1931 Inter-Chamber Health Con-

TABLE 1. *Diphtheria Incidence and Death Rates
In Cincinnati, 1911 - 1930*

Year	Cases	Deaths	Number Hospitalized
1911	582	48	.....
1912	638	60	.....
1913	882	53	.....
1914	1,095	71	.....
1915	904	47	250
1916	1,204	63	240
1917	814	51	233
1918	733	43	302
1919	690	55	314
1920	659	51	181
1921	1,029	69	324
1922	643	50	193
1923	575	23	124
1924	397	19	91
1925	351	14	145
1926	387	17	166
1927	439	23	212
1928	430	26	228
1929	316	22	135
1930*	133	11	93

*Up to December 22

servation Contest conducted by the United States Chamber of Commerce. The crude death rate in 1931 was 15.6 per 1,000 population and the birth rate was 18 per 1,000. The infant mortality rate was 71.0 per 1,000 live births recorded. There were 142 cases of diphtheria with 9 deaths. Typhoid fever caused two deaths. No deaths were charged to smallpox and only five cases were reported. Only measles and whooping cough claimed a heavy toll. Tuberculosis took as its victims 511 of our people.

Indigency

Dr. Owen C. Fisk, the Chief Medical Inspector, noted that

unemployment is fully expressed in the medical relief of the indigent. Over 16,000 patients were treated at home and in the offices of the district physicians. This is more than three times the number registered in 1929. Mr. Otto P. Behrer, the Chief Chemist and Bacteriologist, noted that in 1931 the laboratory examined 54,202 specimens . . .

The Clark Street Health Center did good work and is noted as "one of the city's best assets . . ."

(Continued on Page 184)

*Dr. Macleod, Cincinnati, is Commissioner of Health, City of Cincinnati.

Submitted March 16, 1966.

How long will it take him
to recover from the flu
if he just doesn't care?



**Does he really care?
Is he alert, encouraged,
positive and optimistic
about getting out of bed
and back to work soon?**

**Or is he giving in to
the depressing impact
of confinement?**

**When functional fatigue
complicates convalescence,
Alertonic can help...**

Pleasant-tasting Alertonic is pipradrol hydrochloride —an effective cerebral stimulant whose gentle analeptic action helps counteract the apathy and inertia that so often delay convalescence—together with an excellent vitamin and mineral formula, in a satisfying 15% alcohol vehicle.

Nothing fosters confidence and a sense of well-being better than your own personal warmth, understanding and encouragement together with Alertonic to help insure prompt response.

*Adequate dosage is important: Prescribe Alertonic—
one tablespoonful t.i.d., 30 minutes before
meals...tastes best chilled.*

*And for your patient's sake, prescribe Alertonic
in the convenient, economical one-pint bottle.*

Alertonic[®]

Available Only On Prescription

Each 45 cc. (3 tablespoonfuls) contains: alcohol, 15%; pipradrol hydrochloride, 2 mg.; thiamine hydrochloride (vitamin B₁) (10 MDR*), 10 mg.; riboflavin (vitamin B₂) (4 MDR), 5 mg.; pyridoxine hydrochloride (vitamin B₆), 1 mg.; niacinamide (5 MDR), 50 mg.; choline,[†] 100 mg.; inositol,[†] 100 mg.; calcium glycerophosphate, 100 mg. (supplies 2% MDR for calcium and for phosphorus) and 1 mg. each of the following: cobalt (as chloride), manganese (as sulfate), magnesium (as acetate), zinc (as acetate), and molybdenum (as ammonium molybdate).

*Multiple of adult Minimum Daily Requirement supplied.

†The need for these substances in human nutrition has not been established.

Indications: 1. Functional fatigue such as that often associated with: a depressing life experience or stressful time of life; advancing years; convalescence; limited activity or confinement. 2. Poor appetite and vitamin-mineral deficiency as they occur in: patients having faulty eating habits; geriatric patients who are losing interest in food; patients convalescing from debilitating illness or surgery.

Contraindications: As with other drugs with CNS stimulating action, Alertonic is contraindicated in hyperactive, agitated or severely anxious patients and in chorea or obsessive compulsive states.

Side effects: Reports of overstimulation have been rare. Patients who are known to be unduly sensitive to the effects of stimulant drugs should be observed carefully in the initial stages of treatment.

Dosage: Adults, 1 tablespoonful; children (over 15 years old), 1 to 2 teaspoonfuls; children (4 to 15 years old), 1 teaspoonful. To be taken three times daily 30 minutes before meals.

Merrell

THE WM. S. MERRELL COMPANY
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Cincinnati, Ohio 45215

L. K. Tooker, R. N.

Louise K. Tooker, the Superintendent of Public Health Nursing, stated that, The function of the public health nurse of the Cincinnati Health Department is not only to prevent illness but to do everything within her power to bring to each person in her district a chance of complete health. The Health Department, during 1931, employed 46 nurses, two supervisors, a superintendent of nursing, two stenographers and a typist. The staff headquarters are in the Health Center, 934 Clark Street, where daily the nurses assist in the prenatal, infant, heart, tuberculosis, and venereal clinics . . .

The issue Vol. VI, No. 1, dated April 1, 1933 is the last issue of CINCINNATI'S HEALTH under the editorship of Dr. William H. Peters, who ended his commissionship that year. The most interesting item in the issue is entitled "48 Dead" and is a discussion of the wreck of the dirigible R-101. It was a terrible tragedy. A nation went into mourning and the whole world was shocked. A battleship carried the bodies home and they lay in state in Westminster Abbey. [And today in mass death in airplane disasters and others we merely shrug the shoulders and perhaps murmur *c'est la vie* . . .]

Dr. Owen C. Fisk: 1933-1936

Reporting on the situation in 1933 Dr. Owen C. Fisk, acting Health Commissioner, noted:

The Health Department, with less money and less personnel, has done more work than in any year before. Last year Cincinnati was signally honored by winning among cities of its population class in the 1932 Inter-Chamber Health Conservation Contest first place . . .

In this same issue the advantages of "health insurance" is discussed. Also, "the eradication of tuberculosis in livestock." The record of the decline of tuberculosis in swine is noted with statistics (page 10).

He notes with pride in the issue for April 1, 1935: Following the cholera epidemic in 1866 in Cincinnati, as throughout the nation, a lively interest awakened in public health which resulted in a newly organized Board of Health. The spirit that incited these pioneers has weathered the storm of many political upheavals. Changes in practice and administration have been many, in step with knowledge gained through science and experience, but the public health of our community is still a paramount issue . . .

The Board of Health of the city is composed of five members who serve gratuitously. They are appointed by the Mayor for a period of 10 years, which insures continuity of policy and freedom from political activity. The members are M. B. Brady, M.D., President; William B. Wherry, M.D., Vice-President; Clyde P. Johnson, Sol H. Freiberg, and William Muhlberg, M.D., members.

Dr. Fisk noted in some detail in this same annual report the downward trend in the communicable diseases:

Diphtheria: 252 cases in 1934 with 25 deaths as compared with 1,095 in 1914 with 71 deaths. He writes additionally, however:

Science has made available toxoid for the eradication of this disease; but all is in vain unless those whose duty it is ac-

cepts their responsibility so that every child upon reaching the age of six months shall be afforded this protection.

Smallpox: Not a single case reported in 1934.

Typhoid Fever: 16 cases and 7 deaths in 1934.

Epidemic Cerebrospinal Fever: A flare-up occurred resulting in 34 deaths out of 51 cases.

Measles: 2,945 cases with 38 deaths.

Scarlet Fever: 1,235 cases with 28 deaths.

Whooping Cough: 438 cases with 38 deaths.

Tuberculosis: 526 cases reported (283 among the colored population) and 431 deaths from the disease (206 of them among the colored).

Venereal Disease: 2,395 adult cases and 343 cases in children.

Medical Relief of the Indigent: "The demand for medical service upon the district physicians continues unabated." During 1934 they made 20,838 home visits and had 29,616 office visits. The number of patients totalled 16,005 seen at home, and 20,527 in the office. [Surely a reflection of the post-depression years.]

Chest X-Rays:

In 1932 the Western and Southern Life Insurance Company presented the Diagnostic Chest Clinic of the health center with an x-ray unit which has greatly enhanced its service to the community. This unit is supervised by Dr. Kennon Dunham and his assistant Dr. John Skavlem . . .

Total Expenditures of Department: The total expenditures in the department were \$210,849.80 in 1934 at a per capita cost of \$0.46.

[Dr. Fisk died on March 27, 1964, in Florida. — CINCINNATI ENQUIRER, March 27, 1964.]

Dr. F. K. Harder: 1935-1938

Dr. F. K. Harder succeeded Dr. Fisk as Acting Commissioner of Health. During his first year in office the death of former health commissioner William H. Peters occurred. Dr. Peters had served the department a total of 22 years.

During his second year in office (1936), Dr. Harder noted the progress of Cincinnati's health in statistical form. He notes the following points of progress:

A program of intensifying diphtheria immunization. Use of two doses of precipitated toxin begun.

Inauguration of a postpartum clinic at health center.

A complete monthly report in place of an annual report prepared by the State Health Department.

Substitution of the photostatic method for typewritten copies of births and deaths in the Bureau of Vital Statistics.

A central filing system instituted at the health center.

Regulation for "regulating the food for dairy cattle producing milk to be sold in Cincinnati."

Regulation for regulating the temperature in public buildings.

(Continued in March Issue)



Scientific Section

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FEBRUARY, 1967

No. 2

Cardiopulmonary Resuscitation

JOHN H. KENNEDY, M.D., DAVID S. LEIGHNINGER, M.D., DANIEL K. BLOOMFIELD, M.D.,
HENRY KRETCHMER, M.D., and F. A. SIMEONE, M.D.

AT THE invitation of the Chronic Disease Control Branch, U. S. Public Health Service, an interdisciplinary Instructor's Workshop on Cardiopulmonary Resuscitation was held at Cleveland Metropolitan General Hospital on January 4, 1966. For the sake of brevity, the following synopses were prepared by each of the participants.

DR. KENNEDY: Cardiorespiratory arrest from a variety of causes occurs an average of once a week at our institution. During a two year period, 41 per cent of 119 patients recovered completely following closed and/or open chest cardiac resuscitation.* Our management of this sudden catastrophe has been based on the principle that expired air ventilation and closed chest cardiac massage carried out by the nearest person will yield the highest recovery rate. This implies a hospital-wide program for continuous reinstruction for all hospital personnel, carried out quarterly.

In general, open chest cardiac massage is recommended if, by the time that all necessary personnel and equipment for an emergent thoracotomy are at the scene, effective cardiac action has not been restored. Principles of open chest cardiac resuscitation are taught as a laboratory course to the resident staff assigned to surgery and to the surgical subspecialties.

An extended form of cardiopulmonary resuscitation now under clinical study is the use of the heart

lung machine for assisted circulation in selected patients who do not respond to the conventional measures. Of eight patients in whom cardiac arrest

For editorial comment see page 147

had proved refractory to open or closed chest cardiac massage, all but one patient could be resuscitated and survived hours to days. One patient recovered completely and left the hospital without evidence of a neurologic deficit or a change in personality.

The technique of assisted circulation included open chest left heart bypass in two patients, and femoral vein-to-femoral artery perfusion with an oxygenator in six. The average duration of preliminary resuscitative efforts was 15.8 minutes and perfusion was carried on for an average of 59 minutes.

This extended application of clinical perfusion techniques implies the availability of a rapidly preparable heart lung machine and a trained team. A disposable bubble dispersion oxygenator is kept primed with lactated Ringer's solution. Serial cultures have shown that the fluid remains sterile for at least one month. Tubing and cannulae are kept connected and covered with sterile cellophane tubing to permit rapid handling without risk of contamination. A series of "fire drills" is held in the laboratory.

DR. LEIGHNINGER: Cardiac resuscitation has proved its usefulness through the years of open chest resuscitation and more recently closed chest resuscitation. There are today thousands of living "victims" who attest to this fact. There are, however, literally hundreds of victims every day who die with hearts

From the Departments of Medicine and Surgery, Western Reserve University School of Medicine and Cleveland Metropolitan General Hospital, Cleveland, Ohio 44109. Presented at an Instructor's Workshop on Closed Chest Cardiac Resuscitation held January 4, 1966, at C. M. G. H. under the auspices of the United States Public Health Service.

*Data prepared by Harold G. Peters, M.D., and reported elsewhere.

that could be made to beat again if the right thing had been done at the moment of death. The vast majority of these deaths are in victims of the fatal heart attack. Recent evidence¹ supports the concept that many of these victims have hearts "too good to die." Herein lies the future of resuscitation.

To meet the challenge of the heart that needs a second chance to beat, resuscitation must be available in three areas:

A. The Scene of Death. Since the brain dies within three to five minutes, resuscitation must be started immediately at the scene of death by whomever happens to be present. The mission here is to keep the brain alive and to summon help. This area involves the lay rescuer.

B. Transportation of Victim. Action must be continued during transportation of the victim to a medical center. Again, the mission is to keep the brain alive. This area involves the rescue squad.

C. Treatment at the Medical Center. Action must be continued at the medical center to keep the brain alive while efforts are being made to start the heart beating well enough to maintain an adequate circulation. This area involves hospital personnel, nurses, and doctors.

Resuscitation Technique

Emergency action consists of blowing up the lungs with air and pumping red blood to the brain. One without the other is ineffective. Both must be done at the same time.

The most effective way of getting air into the lungs is by mouth-to-mouth respiration. The airway must be free of foreign material. The airway is opened by hyperextending the head. The head tilt position forces the tongue and jaw forward so they do not block the airway. One hand is placed under the neck and the heel of the other hand on the forehead. The thumb and forefinger of the hand on the forehead are used to pinch the nostrils closed. The rescuer takes a deep breath and opens his mouth widely so as to completely encircle the victim's mouth. The rescuer presses his lips tightly against the victim in order to make an airtight seal, and blows hard enough to lift the chest of the victim. The rescuer then turns his head to look at the chest of the victim. Adequate quantities of air can be forced into the lungs by this means.

Artificial circulation is maintained by squeezing the heart between the sternum and the spine. The victim must be on a solid support such as the floor or ground. The rescuer kneels beside the victim and places the heel of one hand on the lower half of the sternum. The other hand is placed on top of the first hand. The rescuer and his hands are at right angles to the sternum. Care must be exercised not to place the hands too high, too low, or off to either side. The sternum is depressed a distance of $1\frac{1}{2}$ to 2 inches. From 70 to 120 pounds pressure may be re-

quired for an adult. Pressure is released but the hands are not removed from the proper position on the sternum. This action is repeated at the rate of once a second — 60 times a minute.

Resuscitation by One Rescuer. If only one rescuer is present he first blows air into the lungs three to five times, then quickly changes position and compresses the chest 15 times. Then quickly blows up the lungs two times. The action is continued with a ratio of 2 blows to 15 compressions. This action is not as effective as resuscitation by two rescuers.

Resuscitation by Two Rescuers. One person blows up the lungs while the second rescuer compresses the chest. Chest compression is continued uninterrupted while air is blown into the lungs after every fourth chest compression. The ratio is now four to one, 60 chest compressions per minute and 15 lung inflations per minute. This action is superior because chest compression is not interrupted. When one rescuer tires he can change places quickly without interrupting the action.

The heart stops in either standstill or fibrillation. The standstill heart needs circulation of red blood through the myocardium to restore heart action. Electric countershock is not necessary. Closed chest resuscitation alone will restore heart action.

The fibrillating heart requires an electric countershock. The human heart will occasionally defibrillate spontaneously. The myocardium must be pink before the shock is given. If AC current is used, the voltage required varies from 480 volts to 700 volts and the duration of shock is about one quarter of a second. Direct current shocks require from 100 to 400 Watt Seconds and are about 1/200th second duration.

Until the heart beat is strong enough to maintain an adequate circulation, closed chest resuscitation should be continued. The weakly beating heart can be supported and helped by continuing the action. When properly done, closed chest resuscitation will not traumatize the victim.

This simplified, direct approach to resuscitation training has, in our hands, proved to be useful no matter how sophisticated the group. It is our hope that widespread training in the technique may help meet the challenge of the "heart too good to die."

DR. BLOOMFIELD: Coronary Care Units. Coronary care units are here to stay. Numerous reports give encouraging evidence of their efficacy. The coronary care unit will soon be as much a part of hospital care as the operating suite. At a recent meeting of cardiologists, no fewer than 38 companies displayed devices for cardiac monitoring or defibrillation. In such a rapidly developing area, it seems worthwhile to present guidelines to assist physicians in planning their needs.

There is a simple beauty to the unique needs of cardiac resuscitation. The elements of success include: (1) A monitor system, (2) A trained person immediately available to respond to the emer-

gency, (3) A communication system to transmit the call for help, (4) Drugs and electrical equipment to reverse the catastrophe of the "fatal" arrhythmia, and (5) A resuscitation team.

These essentials must remain clearly in focus when trying to sort through the many products and systems that dazzle our eyes. The first cardiac monitor "developed" by Dr. Paul Zoll in the early 1950's, was a true prototype that has never been excelled in theory. Renting for only \$25 per month, it contained an alarm system, automatically started electrocardiographic recording, and possessed a memory. It was called "house officer" and its only drawback was that, unlike its electronic counterpart, it suffered from fatigue. The cardiac monitor, therefore, is any device, human, mechanical, electronic, or type unborn, that will relay the necessary information to the second element of the resuscitation unit, the person or object trained to respond. The responding element, which is also human at the time of this writing, but could be mechanical or electronic in years to come, must be able to react to the emergency by beginning the mechanical act of pumping the heart and initiating a call for help to the rest of the resuscitation team.

The logistics involved are not demanding. Review of reports suggests that a cardiac emergency on coronary care units will occur about once every 640 patient hours, or once per week on a four-bed unit. Proper staffing demands only the 24-hour presence of a single capable, alert person in a four-bed or eight-bed unit—a size adequate for most hospitals in this country. The communication system to the rest of the team can be as simple as an emergency switch direct to the hospital paging operator. When the switch lights a lamp on the operator's board, an immediate page can be made to the hospital team. Meanwhile, the trained person—doctor, nurse, or even lay resuscitator—can initiate the pumping-breathing maneuvers that buy time necessary to assemble resuscitation forces.

Resuscitation equipment and drugs must be available in the coronary care unit. Basically, a defibrillator-pacemaker combination is necessary to handle the two chief causes of cardiac death, ventricular fibrillation and ventricular standstill. Drugs can be divided into three categories: (1) Major antiarrhythmic drugs, such as digitalis, quinidine, and procaine amide; (2) Minor antiarrhythmic agents, such as Dilantin®, pronethalol, potassium, chelating agents, lidocaine, and atropine, and (3) Drugs which restore the metabolic stability of the heart, such as oxygen, alkalinizing agents, calcium, and sympathomimetic amines. The only certain feature concerning the use of these tools of resuscitation is that the lists will be expanded and changed in years to come. Methods of defibrillation, whether AC or DC, and adjunct drugs will improve as researchers and manufacturers strive for perfection.

The physician organizing a coronary care unit in

The Participants

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● Dr. Leighninger, Cleveland, is Assistant Surgeon, Lakeside Hospital; Assistant Professor of Surgery, Western Reserve University School of Medicine.

● Dr. Bloomfield, Cleveland, is Associate in Medicine and Director of Clinical Hypertension Research, Mount Sinai Hospital; Senior Clinical Instructor in Medicine, Western Reserve University School of Medicine.

● Dr. Kretchmer, Cleveland, is Director, Department of Anesthesia, Cleveland Metropolitan General Hospital; Associate Professor of Anesthesiology, Western Reserve University School of Medicine.

● Dr. Simeone, Cleveland, is Surgeon, Cleveland Metropolitan General Hospital; Associate Surgeon, University Hospitals of Cleveland; Professor of Surgery, Western Reserve University School of Medicine.

1966 should be guided by the broad principles outlined above and be prepared to modify his approach as scientific knowledge of resuscitation increases.

DR. KRETCHMER: *The Role of the Anesthesiologist.* Most physicians who have been concerned with teaching cardiac massage have seen patients lost where everything is ideal. In these instances, the effectiveness of the cardiac massage is in doubt. In order to increase the frequency of success, one should resuscitate on suspicion. I have seen instances where attempts to palpate for carotid or femoral pulses have caused loss of perhaps five minutes of valuable time. Resuscitation must be instituted immediately. Confirmation of the diagnosis can be deferred until later.

In patients with suspected cardiac arrest outside the operating room it is a good idea to raise both legs. In an adult this will add approximately 500 ml. of blood to the venous return to the heart. The greatest stimulus for ventricular contraction is the expansion of the ventricle by blood.

It is axiomatic that a clear airway must be maintained. Intubation should be attempted during a period when the heart is relatively oxygenated. Here, one should not persist in attempts at intubation. If the attempt is made and the tube is not positioned properly, keep pumping the chest rhythmically again, ventilate the patient again, wait for two or three minutes and then try again. It is not essential to intubate a patient except where an airway cannot be established by mouth-to-mouth resuscitation or with

a mask and bag. Preservation of effective alveolar ventilation is essential. One must remember that in an adult, it is difficult to ventilate with too much pressure by mouth-to-mouth respiration. Unless the patient has some form of lung disease or is a small child, it is very difficult to rupture an air sac by mouth-to-mouth respiration.

Of increasing importance is the conduct of the postoperative period. Anoxia, even for relatively short periods, causes the brain to swell and it is important to employ measures which tend to reduce edema. Hypothermia protects against the effects of anoxia. The role of selective cerebral hypothermia is now under study.

Re-education of personnel in the method of resuscitation should be a continuous one. It is amazing how quickly people forget. In addition, in a situation which occurs rarely, the equipment gets scattered.

DR. SIMEONE: *Summing Up.* I take this opportunity first of all to congratulate the pioneers, such as Dr. Beck, whose work has been discussed today. Among the pioneers was my classmate the late Dr. Lampson of Hartford who successfully resuscitated a boy who developed ventricular fibrillation during herniorrhaphy in 1948. Today, you have heard discussed the role of drug therapy and of electrical stimulation in the management of arrhythmias leading eventually to ventricular fibrillation and arrest. I need add nothing to that, but I want to emphasize one point. In the event of serious cardiac arrhythmia or arrest, time is a major determinant of success or failure. To waste time looking for equipment or learning how to use it is inexcusable. The mere existence of a plan of action on paper is insufficient. All personnel who are likely to be involved in this kind of resuscitation must constantly know where and what the equipment is and how to use it. The apparatus must be in a constant state of readiness. It must be checked daily. Vacuum tubes and transistors have a vicious habit of being in order at the time the apparatus is turned off and of being totally nonfunctioning when turned on a short time afterward. *The vital importance of a constant training program cannot be overemphasized.*

Dr. Kretchmer has discussed the importance of hypothermia and ventilation for cardiopulmonary resuscitation. It is difficult to assign a priority between establishing a cardiac beat and providing adequate pulmonary ventilation. Both functions are of vital importance, and ideally, both should be restored simultaneously. Restoration of blood flow

is of first importance and one must depend primarily on rhythmic artificial contraction of the chambers of the heart. It is true that artificial respiration does exert a massaging action on the blood within the great vessels but this is of relatively minor importance. Even a brief period of circulatory arrest causes a profound metabolic acidosis. This must be corrected by the use of such agents as sodium bicarbonate, or THAM.

Hypothermia has provided a field for interesting investigation. It has been stated that nowadays hypothermia is used for everything except that for which it originally was intended. Those who use hypothermia must carefully think through the objectives for using it. Surely a decrease in the rate of oxygen consumption is effected, but by the same token reparative processes are slowed down. When some form of derangement has resulted in failure of the circulation, it is not sufficient merely to decrease the absolute need for the circulation; one must also stop the cause and provide for the repair of the abnormality which gave rise to the circulatory failure in the first place. Another point to consider about hypothermia is that while the tissue requirement for oxygen is decreased, it becomes less available to tissue, so that one doesn't necessarily come out ahead. Cold increases the viscosity of blood, therefore interfering with the rate of circulation. Oxygen is made less available and metabolic acidosis results.

There are situations where the limiting factor in the failing circulation is failure of the heart itself. The possible role of temporary assistance of the circulation has been discussed by Dr. Kennedy; there may be some future to implantation of an artificial heart in these patients. It is noteworthy in this connection, that the failing heart derives little help from partial take-over of its circulatory load. This has to be nearly complete if it is going to do much good.

Finally, let me emphasize again the importance of training, and continued periodic training in this field. One is dealing here with a true emergency in which every minute counts and determines the difference between success and failure. All personnel, medical, and paramedical, must be thoroughly familiar with equipment and with procedure. Constant attention must be given to training if precious time is to be saved when the emergency arises.

Reference

1. Adelson, L., and Hoffman, W.: Sudden Death from Coronary Disease. *J. A. M. A.*, 176:129-135 (April 15) 1961.

OHIO'S No. 1 POSTGRADUATE PROGRAM OF THE YEAR: The 1967 Annual Meeting of the Ohio State Medical Association, Columbus, May 16-19. Make your plans now to attend.

D.C. Countershock in the Treatment Of Arrhythmia

Immediate and Long Term Results

O. MASSARANI, M. D., E. M. GOYETTE, M. D., and H. A. ZIMMERMAN, M. D.

DIRECT current countershock has been the method of choice for terminating cardiac arrhythmias since 1962 when Lown's studies demonstrated that a properly synchronized direct current discharge can depolarize the heart with complete avoidance of either ventricular or atrial fibrillation.¹

During the past two years, we have used the cardioverter* for the treatment of atrial or ventricular arrhythmias. This paper presents experience with 250 episodes of atrial fibrillation, atrial flutter, supraventricular tachycardia, and ventricular tachycardia in 184 patients with follow-up studies.

Method of Study

At least 24 hours prior to the conversion, 90 per cent of the patients received quinidine or procaine amide hydrochloride and were maintained on it as long as they remained in normal sinus rhythm. Eighty per cent of the patients received digitalis and were maintained on it until after the conversion.

The patient's age ranged between 14 and 84 years (Table I), 60 per cent being between 40 and 60 years of age. The duration of the arrhythmia varied from a few hours to 41 years. The patients were classified according to the etiology of their heart disease (Table 2); 60.8 per cent of the total cases had rheumatic heart disease and 28 per cent had arteriosclerotic heart disease. The types of arrhythmia were classified as follows: 76.8 per cent of the episodes were atrial fibrillation, 10.4 per cent were atrial flutter, 7.6 per cent were supraventricular tachycardia and 5.2 per cent were ventricular tachycardia (Table 3).

One hundred and forty-two attempts at conversion were done in 98 patients at various times following surgery, 97.8 per cent had rheumatic heart disease: one fourth of these had pure mitral stenosis and one fourth had combined mitral stenosis and regurgitation, 3.6 per cent had pure mitral regurgitation

The Authors

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- Dr. Goyette, Cleveland, is Chief of Medicine and Chief of Cardiology, Huron Road Hospital.
- Dr. Zimmerman, Cleveland, is Director, Marie L. Coakley Cardiovascular Laboratory, and Chief, Cardiovascular Laboratory, St. Vincent Charity Hospital.

and the remainder had aortic or combined aortic and mitral valvular disease (Table 4).

One patient with congenital heart disease was defibrillated two and a half years after the closure of an ostium secundum defect, and a patient with constrictive pericarditis was successfully converted, at one year and again two years after pericardiectomy.

Seventeen patients had cardioversion on an Out-patient basis and were discharged after 30 to 60 minutes of observation in the recovery room. All cardioversions were done either in the operating room or recovery room.

Light anesthesia was induced in 233 patients by using sodium thiopental 2 per cent, followed in some cases by nitrous oxide and oxygen in a 6 liter to 2 liter ratio. The dosage of thiopental ranged from 100 mg. to 1 gram. Halothane was used in addition to the above agents in four cases and Sodium Breivital® was used in four others. All patients were responding and fully awake within minutes after cardioversion.

Seventeen patients received a total of 26 precordial shocks without anesthesia, six of these were semi-conscious and in shock with ventricular tachycardia and needed no sedation. The other 11 patients were fully conscious and alert; nine of these had atrial fibrillation, one had atrial flutter and one had paroxysmal atrial tachycardia. All of the patients were premedicated with meperidine or morphine and

From the Departments of Cardiovascular Disease, St. Vincent Charity Hospital, and Huron Road Hospital, Cleveland, Ohio. Submitted May 3, 1966.

*Corbin-Farnsworth.

secobarbital 30 to 60 minutes prior to the conversion. One patient was given three shocks while awake but without success, then a fourth shock of 300 watt/second was applied after the patient was anesthetized and the arrhythmia was converted. A right lateral recumbent position was used in 11 of these patients, one paddle was applied posteriorly and the other placed anteriorly over the left side of the chest.

Results

Of 250 episodes of arrhythmias, 208 were immediately converted to normal sinus rhythm (Table 5).

Table 6 shows the rate of immediate success according to the etiology of the heart disease. Fifty-nine patients with arteriosclerotic heart disease were converted to normal sinus rhythm (84.5 per cent) and 11 patients failed to convert (15.7 per cent). Among the rheumatics, conversion was also achieved in 84 per cent of the episodes. In patients with combined rheumatic and arteriosclerotic heart disease, 16 converted (69.56 per cent) and seven failed to return to normal sinus rhythm (30.44 per cent). The two episodes of atrial fibrillation in the patients with congenital heart disease as well as the patients with constrictive pericarditis and myocarditis were successfully converted to sinus rhythm.

On the cases in which the conversion was attempted postoperatively, successful results took place in 91.6 per cent of the patients with pure mitral stenosis and in only 60 per cent of the cases with pure mitral regurgitation. Among the patients operated upon for combined mitral stenosis and regurgitation, 77.7 per cent were converted to sinus rhythm.

Following conversion, transient arrhythmia consisting of multiple premature beats of ventricular or auricular origin lasting from a few seconds to a few minutes was often noted. In many cases, the P waves were notched and of high amplitude or bifid for a period of 10 to 15 minutes, then their configuration returned to normal.

Erythema was noted at the site of application of the paddles; this disappeared two to three days later. Some patients complained of a slight soreness of these areas.

Case History: An especially interesting case history is that of a 50 year old woman, known to have rheumatic heart disease, who had undergone a mitral valvulotomy under direct vision for the correction of mitral stenosis in May 1960 and an open mitral commissurotomy with mitral annulus plication was performed in August 1964. On March 24, 1965, the mitral and tricuspid valves were replaced by the discoid (Kay-Suzuki) prosthetic valves. On the following day, the patient was taken to the operating room again for evacuation of blood clots from the right hemithorax; at 2:55 P. M. she began to show bigeminy and runs of premature ventricular contractions. This was followed by several short runs of ventricular tachycardia and fibrillation lasting 6 to 10 seconds each. Procaine amide hydrochloride was given intravenously without beneficial results.

Since the blood pressure began to drop, Aramine® was given by intravenous drip. In spite of additional doses of intravenous procaine amide hydrochloride, these bouts of

TABLE 1. Age Range: 14 Years to 83 Years

Age (Years)	No. of Patients
10 - 19	1
20 - 29	3
30 - 39	13
40 - 49	52
50 - 59	59
60 - 69	33
70 - 79	20
80 - 83	3
Total	184

TABLE 2. Etiology of Heart Disease

	Episodes	No. of Pts.	%
Rheumatic Heart Disease	152	114	60.8
Arteriosclerotic Heart Disease ..	70	55	28.0
Rheumatic Heart Disease and Arteriosclerotic Heart Disease ..	23	11	9.2
Congenital Heart Disease	2	2	0.8
Constrictive Pericarditis	2	1	0.8
Myocarditis	1	1	0.4
Total	250	184	

TABLE 3. Type of Arrhythmias

	No. of Episodes	No. of Patients	%
Auricular Fibrillation	192	141	76.8
Auricular Flutter	26	22	10.4
Ventricular Tachycardia	13	10	5.2
Supraventricular Tachycardia	19	12	7.6
Total	250	185	

(Duration of arrhythmia ranged from a few hours to 41 years.)

TABLE 4. Postoperative Cases

	No. of Episodes	No. of Patients	Successful Conversion (Episodes)
I. Rheumatic Heart Disease			
A. Tricuspid Valve Disease	2	2	2
B. Mitral Valve Disease			
Mitral Stenosis	36	26	33
Mitral Insufficiency	5	4	3
Combined Mitral Stenosis and Insufficiency	36	30	28
C. Aortic Valve Disease	10	8	8
D. Combined Mitral Valve Disease and Aortic Valve Disease	50	26	41
Total	139	96	115
II. Congenital Heart Disease	1	1	1
III. Constrictive Pericarditis	2	1	2

TABLE 5. Immediate Results According to Type of Arrhythmia

	Episodes	%	Patients	%
Auricular Fibrillation	157 (81.77%)		35 (18.23%)	
Auricular Flutter	21 (80.7%)		5 (19.3%)	
Supraventricular Tachycardia ..	17 (89.4%)		2 (11.2%)	
Ventricular Tachycardia ..	13 (100%)		....
Total	208 (83.2%)		42 (16.8%)	

ventricular arrhythmia became more frequent and more prolonged, lasting up to 1½ minutes. Direct electric shock was applied for the first time at 6:10 P. M. and the rhythm converted immediately to nodal rhythm, followed by sinus rhythm. Five to 10 minutes later another episode of ventricular arrhythmia occurred, which was terminated by another direct current shock. These shocks had to be repeated every 5 to 10 minutes because of recurrence of ventricular arrhythmia. In a five hour period a total of 17 direct current shocks were given.

Soon after 11:00 P. M. sinus and nodal rhythm persisted, but the patient's blood pressure had to be maintained with Aramine intravenously until the next day. On the following morning she had two episodes of ventricular fibrillation, lasting 30 seconds. Both times conversion to sinus rhythm occurred after direct current shock.

The patient was confused and disoriented all day, but the following morning she was alert and well oriented. A few days later she was taken to surgery for evacuation of a hemopericardium and since then she has done well. It is interesting to note that in August of 1964, following her second operation, this patient had two bouts consisting of short runs of ventricular tachycardia which converted spontaneously.

Complications

In six patients (2.4 per cent), ventricular fibrillation occurred with one fatality (0.4 per cent) and one patient had a short episode of standstill. These are listed in Table 7. As can be seen from this table, the first two patients were shocked immediately after ventricular fibrillation occurred and the rhythm reverted to auricular fibrillation in one and to normal sinus rhythm in the other. It is of interest to know that the second patient was not under anesthesia.

The third patient was a 68 year old woman with arteriosclerotic heart disease who had had a myocardial infarction 18 months previously. In December 1964, she was first converted to normal sinus rhythm with 100 w/sec. direct current shock. This was done on an Outpatient basis. Following the shock, she developed an allergic reaction to quinidine, and the drug was discontinued. Two weeks later she reverted to atrial fibrillation and a month later she returned to the hospital for another attempt at conversion, after which she was started on procaine amide hydrochloride. Ventricular fibrillation appeared immediately after one shock of 100 w/sec. To counteract this arrhythmia another shock was given and the

rhythm converted to normal sinus rhythm. A few minutes later, ventricular fibrillation reappeared and another shock was given, again successfully converting the arrhythmia to normal sinus rhythm, but lasting only for 5 to 10 minutes. After this short period of normal rhythm, ventricular tachycardia and fibrillation reappeared. This pattern continued until a repeated number of shocks were given. Following

TABLE 6. *Immediate Results According to Etiology of Heart Disease*

	Converted	Not Converted
Rheumatic Heart Disease	128 (84.21%)	24 (15.79%)
Arteriosclerotic Heart Disease....	59 (84.3%)	11 (15.7%)
Rheumatic Heart Disease and Arteriosclerotic Heart Disease....	16 (69.56%)	7 (30.44%)
Congenital Heart Disease	2 (100%)	....
Myocarditis	1 (100%)	....
Constrictive Pericarditis	2 (100%)	....

the initial shock, the patient lived for 27 hours during which she was shocked 80 to 100 times with only temporary conversion each time.

In the fourth and fifth cases, cardiac massage was applied soon after the appearance of ventricular fibrillation and the rhythm reverted to the original one. In one of these patients, two more shocks were given and the rhythm converted to normal sinus rhythm.

In the case of the sixth patient, a short episode of ventricular fibrillation occurred following the shock, but was spontaneously followed by ventricular tachycardia, bigeminy, and finally normal sinus rhythm.

A short episode of cardiac standstill occurred in the seventh patient following each shock. Sinus rhythm was restored after a brief period of external massage.

Follow-Up Study

Follow-up data were secured on all but four of the patients. Sixty-six per cent of the patients reverted to their preconversion arrhythmia and only 28.4 per cent remained in normal sinus rhythm. Seven patients died a few months after conversion,

TABLE 7. *Complications*

Patient	Age	Etiology	Diagnosis	Complications	Treatment	Follow-Up
G. G.	70/M	ASHD	A. F.	V. F. aft. 4th shock	1 shock - A. F.	A. F.
J. M. (no anes.)	47/M	ASHD	A. F.	V. F. aft. 2nd shock	1 shock - N. S. R.	N. S. R.
H. McL.	68/F	ASHD	A. F.	V. T. & V. F.	80 - 100 shocks with no success	Died 36 hrs. later
W. McC.	39/M	CHD	A. F.	V. F. aft. 1st shock	ext. massage - A. F. 2 more shocks N. S. R.	N. S. R.
D. F.	59/F	RHD	A. Flut.	V. F. aft. 1st shock	ext. massage - A. flutter	A. flutter
J. A.	45/F	RHD	A. F.	V. F. - V. T. - Bigem. - N. S. R.	No treatment	A. F. 1 yr. later
L. J.	44/F	RHD	A. F.	Cardiac standstill	Brief cardiac massage - N. S. R.	A. F. 4 days later

and the rhythm at the time of their death was unknown. Four patients did not report for follow-up electrocardiogram; however three of them were seen 9 to 10 months after their conversion and were found to have a normal sinus rhythm (Table 8).

Failure to maintain sinus rhythm: Within 24 hours, 49 of the conversions returned to the previous arrhythmia (23.5 per cent); within two weeks a total of 88 conversions reverted (42.5 per cent). This number gradually increased so that at the end of one year, 129 patients reverted to their original arrhythmia (62.5 per cent), and after two years, the reversion percentage was 63.5 per cent (Table 9). Five others, reverted to their previous rhythm, however the time of their reversion was unknown.

Still maintaining normal sinus rhythm: Of five conversions done two or more years ago, only one maintained normal sinus rhythm.

One hundred and thirty-seven attempts were made on 119 patients between one and two years ago. Of these, 28 patients still maintain a normal sinus rhythm (23.5 per cent). Two patients died within two months after conversion and they were in normal rhythm shortly before their death.

During the last year, 108 attempts at conversion were made on 59 patients, many of them having been shocked previously. Of these, 28 patients are still in normal sinus rhythm (Table 10).

Slightly better results were obtained in patients with rheumatic heart disease as 30.75 per cent of them remained in sinus rhythm, while only 25.4 per cent of the patients with arteriosclerotic heart disease maintained a normal rhythm after conversion (Table 11).

Discussion

The dangers of chronic atrial fibrillation have been known for a long time—02.5 to 5 per cent of patients with chronic atrial fibrillation die suddenly.²

Embolization: During atrial fibrillation³ mural thrombi tend to form in either or both atria. This occurs regardless of the etiology of the fibrillation. Approximately 30 per cent of all individuals with chronic atrial fibrillation experience one or more serious embolic phenomena during the course of fibrillation. In mitral stenosis 90 per cent of emboli occur in association with atrial fibrillation. Ten to 20 per cent of all deaths in rheumatic heart disease result from emboli.⁴

Chronic atrial fibrillation results in a reduction of cardiac output by as much as 40 per cent and also causes a reduction in blood flow.⁵ Even though the ventricular rate in atrial fibrillation may be maintained within the normal range with digitalis and result in a normal resting cardiac output, the latter will not rise with exercise to the degree which would occur when sinus rhythm is present.

Return to normal sinus rhythm results in an in-

TABLE 8. *Follow-Up: Conclusion*

	Episodes	%
Reverted	138	66.3
Remaining in NSR	59	28.4
Unknown (died)	7	3.4
Unknown (follow-up)	4	1.9
Total Converted	208	100%

TABLE 9. *Follow-Up Study: Reversions to Previous Arrhythmias*

Time Interval Before Reversion	Episodes	% Reverted
Before 24 hours	49	23.5
2 weeks	88	42.3
1 month	100	48.0
3 months	117	56.2
6 months	123	59.1
12 months	129	62.0
2 years	133	63.9
(Time of reversion unknown)	(5)	66.3

TABLE 10. *Follow-Up Study: Patients Remaining in NSR.*

Time Interval	Patients
Over 2 years	1
1 - 2 years	28
6 - 12 months	4
3 - 6 months	11
Under 3 months	13
Died within 2 months while still in NSR	2
Total	59 (28.4%)

TABLE 11. *Follow-Up: Patients Remaining in NSR (According to Etiology of Heart Disease)*

	Patients
Rheumatic Heart Disease	35
Arteriosclerotic Heart Disease	14
Rheumatic Heart Disease and Arteriosclerotic Heart Disease	4
Congenital Heart Disease	2
Constrictive Pericarditis	1
Myocarditis	1
Died in Normal Sinus Rhythm:	
Arteriosclerotic Heart Disease	1
Rheumatic Heart Disease	1
Total	59

crease in cardiac output, increase in blood flow, reduction in central venous pressure, reduction in heart size and a return of cardiac compensation, decrease in incidence of emboli, and relief of disturbing palpitations.⁶

Quinidine: Quinidine has long been the drug of choice for the treatment of most arrhythmias, especially for the conversion of atrial fibrillation and flutter to sinus rhythm.

DeSenac in 1749, first described the use of quinidine for rebellious palpitations. Then Wenckebach in 1914 reported one case of conversion to sinus rhythm with quinidine. In 1921, Levy, in this

country, first described the clinical successes and the toxic effects of quinidine.²

Viko, Marvin and White in 1923, reported 1.8 per cent incidence of sudden death and 3.1 per cent incidence of embolism in a group of patients taking quinidine. In 1929, Parkinson and Campbell reported 4 per cent incidence of sudden death in 544 cases of patients receiving quinidine; in 1946, Askey reported 4 per cent deaths in patients with failure and 1.8 per cent in patients not in failure,⁶ who were taking quinidine.

In 1956 Sokolow⁷ reported 80 per cent conversion with a dose of 3 Gm. of quinidine daily or less.

Various factors influencing conversion were studied, such as rheumatic etiology, duration of fibrillation longer than six months and especially longer than one year, the presence of cardiac failure which did not respond to the usual therapeutic measures and that of mitral insufficiency.⁷

Goldman in 1959-1960² reported his experience in 500 cases. His conversion rate was 82 per cent. The percentage was higher in degenerative heart disease (coronary arteriosclerotic disease or hypertensive cardiovascular disease) and lower in rheumatic heart disease. With predominant mitral stenosis, where the rate of conversion was done to 50 to 55 per cent, while it fell to 20 to 25 per cent when mitral regurgitation was the predominant lesion. The larger the size of the left atrium, the less likely the conversion.

The clinical effect of quinidine in atrial fibrillation is the progressive slowing of the atrial impulse until the sinus node is able to resume its function as the cardiac pacemaker.²

Complications of Quinidine: G. W. Thomason in 1956,⁶ reviewed 611 cases treated with quinidine and found that 20 deaths had occurred (mean fatal incidence of 3.3 per cent).

Embolism was clinically recognized in 23 per cent in a subgroup of 418 cases.⁶ Rosketh, Stostein and Oslo from Norway in 1963,³ reported untoward effects from the use of quinidine in 99 out of 274 patients. Embolism occurred in two patients and sudden loss of consciousness in 12 patients. The American literature alone⁴ has reported 26 deaths associated with the use of quinidine up to 1956.

Electric countershock studies⁸ on the hemodynamic effects of electric countershock, quinidine, procaine amide, and antazoline suggested that electric countershock had the fewest untoward effects on cardiovascular physiology.

Advantages of Direct Current Shock in the Treatment of Arrhythmias:

- A. rapidity of conversion
- B. relative safety
- C. avoidance of delay, uncertainty and possible toxic effect of drugs.

It is indicated in most cases of arrhythmias. In

our opinion the only contraindication to the use of electric countershock is the presence of thrombi in the atrium.

At present there are some conflicting ideas about discontinuing the digitalis prior to the conversion attempt. Miller,⁹ in his studies, withheld the digitalis in half of his patients a day prior and the day of reversion until the attempt was completed. He found that there was no difference between the two groups.

Seventeen of our patients received 26 precordial shocks without anesthesia. Previously in Miller's series,⁹ nine precordial shocks were given to six patients anesthetized. Stock⁵ has applied 29 shocks in 19 of his patients without anesthesia, and Lown¹⁰ has done the same in 10 cases. All these patients, as well as ours, had no undesirable effects.

In the present series, ventricular fibrillation occurred in 2.4 per cent with one mortality (0.4 per cent). Rabbino, Likoff and Dreiffus¹¹ reported three mortalities from ventricular fibrillation following shock in patients considered to have electrocardiographic evidence of digitalis toxicity. They noticed that a period of one-half to two minutes followed each shock before the onset of ventricular fibrillation, implying that factors other than the so-called vulnerable period were responsible. Ross¹² reported one mortality in a patient who developed ventricular tachycardia and ventricular fibrillation after cardioversion. Killip¹³ made reference to a patient who developed ventricular fibrillation twice during cardioversion attempt.

Susseman and co-workers¹³ reported a case of ST segment elevation of two minutes duration after DC shock. All this proves that the use of programmed DC discharge is not fool-proof in the prevention of ventricular fibrillation as shown by the occurrence of this arrhythmia.

Summary

Two hundred and fifty attempts at conversion on 184 patients were presented. The arrhythmias consisted of atrial fibrillation, atrial flutter, supraventricular and ventricular tachycardia; cardioversion was successful in 83.2 per cent of the attempts.

Follow-up studies revealed that 28.4 per cent were in sinus rhythm three months to two years after conversion. Serious complications in 2.4 per cent occurred during the procedure and were consistent of ventricular tachycardia, ventricular fibrillation and cardiac standstill. There was one death (0.4 per cent) in the series which occurred 36 hours following the initial shock (the case is presented in more detail). General anesthesia was used in all cases except 17. Of these six patients were in shock, semiconscious and needed no sedation. The remainder were fully awake and premedicated with meperidine or morphine and secobarbital or pento-

barbital. They all tolerated the electrical shock without any undesirable effect.

A brief historical review of the electrical shock and its use in the treatment of cardiac arrhythmia is presented also, in addition to the latest reports on its use.

We wish to acknowledge our sincere thanks to the attending staff of Huron Road Hospital and St. Vincent Charity Hospital for their cooperation in this study; also our thanks to Miss Marilyn Kuhel for the technical assistance in the collection of the data.

Generic and Trade Names of Drugs

Meperidine — *Demerol*.

Secobarbital — *Seconal*.

Pentobarbital — *Nembutal*.

Procaine amide hydrochloride — *Pronestyl Hydrochloride*.

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PSYCHIATRY IN GENERAL TEACHING HOSPITALS. — It seems that psychiatric patients are usually ill because there are components to their mental state, and an abnormal brain function which stops them, temporarily or permanently, showing the normal degrees of suggestibility essential for the ever-varying adaptation of the whole normal man to his changing environment.

Physical treatments seem able to restore the brain's normal flexibility, and so make it normally suggestible and adaptable again.

The Victorians were probably right when they thought that the main function of doctoring, and even of philosophic and religious doctoring, was to produce a *mens sana in corpore sano*. This means, however, that the mind must often be made well again so as to be able to benefit from the valuable lessons that can be taught to it by our philosophers and priests. But we have to produce a *mens sana* in the mentally and neurotically ill by treatment of the brain itself.

We must stop thinking that the mind of the "whole man" can be made *sana* simply by treating some theoretically disturbed metaphysical humours and vapours, or warring super-egos, egos, and ids; or that the psyche can, so to speak, be made to pull itself up by its own metaphysical bootstraps. This in the past has been the great mistake of doctors, psychiatrists, and even men of God when treating the psychiatrically ill in or out of hospitals of all kinds. They have forgotten what we have had to learn again and again in the past 15 years at St. Thomas's — namely, that brain function can best be brought to normal in exactly the same way that bodily functions have most easily been brought back to normal. And that is by modern empirical, mechanistic, and physiological treatments. Only after this has been done can one set about treating and trying to help the "whole man" with any hope of success. As the great Dr. Samuel Johnson — himself a victim of recurrent melancholia — so aptly put it: "Stay [with me] till I am well, and then you shall tell me how to cure myself." — William Sargent, M. B., F. R. C. P., D. P. M., St. Thomas's Hospital, London: *British Medical Journal*, 2:257-262, July 30, 1966.

Oxygen Therapy as an Adjuvant to Radiotherapy After Mastectomy

Observations on Oxygen by Nasal Catheter At Atmospheric Pressure

ROY H. THOMPSON, M. D.

THE recurrence rate of subcutaneous carcinomatous nodules occurring in the radiated area of postmastectomy patients has been discouraging. A review of the literature shows this to be true in most series.

Williams, Durley, and Curwen in 1953 surveyed 297 postmastectomy patients.⁸ Twenty-eight per cent of them developed recurrences in the skin of the treated area; of these, 53 per cent occurred in the first year, 75 per cent in two years and 91 per cent in the first five years. A solution to the problem is therefore urgently needed.

The role of hyperbaric oxygen in enhancing the effect of radiotherapy in the management of malignant disease has been quite adequately proven.^{3, 4, 7, 9} Tumor tissue is relatively avascular and therefore becomes relatively more sensitive to radiation when its available oxygen supply is increased. This is a selective action as the sensitivity of the host tissue with its normal blood supply is not affected.

These advances in knowledge prompted us to try 100 per cent oxygen inhalation at atmospheric pressure on patients undergoing radiation treatment. After five years of observation we feel that our results are worth reporting.

Methods and Technique

For this study we chose to use consecutive mastectomy patients because (a) the local skin recurrence rate is statistically high in most series, and (b) the local effect is easily observed.

Our method of treatment has been constant over all the cases studied. It consists of single daily increments to one large field posteriorly for five or six sittings followed by a similar field treated anteriorly, to a total minimum skin dose of 2500 rads per field above a line drawn from the suprasternal notch to include the axilla. This is started as soon after mastectomy as the patient will tolerate it, usually

The Author

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within the first few days. This sequence of fields allows more time for healing of the operative sites. Treatment by medial and lateral alternate tangential fields large enough to cover the remaining operative site and chest wall, including the lateral thoracic nodes and the internal mammary chain, follows to the same dosage. A 250 KvP unit is used with a HVL of 1.5 mm of copper.

During the treatment period, the patient inhales oxygen as vigorously as possible through a modified nasal catheter. This modification consists of an ordinary glass connector, sterilized, with one end inserted into the rubber tubing from the oxygen tank and the other inserted snugly into one nostril.

It has been shown by Wooten that oxygenation and radiation must coexist within seconds.⁹ The large "E" cylinder of oxygen is used at a flow rate of 6 to 8 liters per minute. One tank lasts about 90 minutes and is sufficient for the complete course of treatment.

Psychologically, the acceptance of the nasal catheter method is remarkable. The patients feel they are actively contributing something to their recovery. Those with any degree of dyspnea also appreciate the oxygen, especially if supine. An occasional complaint of mucosal dryness is encountered but this has never been found significantly objectionable. No evidence has been found in the literature of complications resulting from short term inhalation of O₂ at atmospheric pressure.⁶

Results

A treated series consisting of 42 consecutive post-mastectomy patients was studied during the period

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from April 1, 1960 to April 1, 1965, a total of 60 months. Only local recurrences were to be considered and only one has occurred to date. This was in a patient with generalized carcinomatosis, including the skin. One patient was lost to follow-up after being free of recurrence for 14 months, and she is not included. The distribution of these cases is shown in Table 1.

TABLE 1. *Recurrence Rate of Treated Series of 42 Consecutive Postmastectomy Patients, April 1, 1960 to April 1, 1965*

Recurrence Period	No. of Patients	%
Recurrence at 2 months	1	2
Recurrence free 12 months	13	31
Recurrence free 24 months	19	45
Recurrence free 36 months	7	17
Recurrence free 48 months and over..	2	5
Total	42	100%

A [treated] control series of 20 consecutive postmastectomy patients prior to April 1, 1960 was reviewed. Over an observation period of 60 months beginning in 1956 and continuing through 1961, a 43 per cent recurrence rate was obtained, distributed as shown in Table 2.

TABLE 2. *Recurrence Rate of Control Series of 20 Consecutive Patients Treated Prior to April 1, 1960*

No. of Patients	%	Time of Recurrence
4	19	12 months
3	14	13-24 months
1	5	25-36 months
1	5	37-48 months
0	0	49-60 months
Total 9	43%	1-60 months

The mastectomies were all performed by 12 of our staff surgeons and varied in degree between simple and radical procedures. The criteria for referral were unchanged throughout both series. There was no change in the operative, postoperative or radiation technique. The survival rate at this writing also appears to be significantly improved by the use of O₂ and a report on this is contemplated at an appropriate future date.

Discussion

Several disciplines are invoked to explain the phenomenon of oxygen enhancement and a brief mention of their contributions is in order as a basis for our survey. These are well documented by Wildermuth, Evans and others.

1. A photon of sufficient energy can free an electron from a water molecule resulting in ionization and instability of the molecule. Oxygen freely available increases this process by a factor approaching 3 over ionization occurring in an anoxic state.^{6,7}

2. Another well regarded theory on the mode of action of O₂ is called the metionic effect.^{6,7} A photon

might disrupt a bond in a molecule of DNA within the chromosome. It has been observed that these breaks usually heal within minutes. In the presence of oxygen ions, a reaction occurs preventing this healing process, and thus chromosomal duplication is prevented.

3. Henry's law states that the quantity of a gas which goes into solution in any given liquid is proportional to the partial pressure of the gas. For example: Alveolar air has a pO₂ of 100 mm of Hg. Therefore the arterial blood with a normal hemoglobin of 15 Gm. per 100 cc. has about the same partial pressure and contains about 19.5 volumes of oxygen per 100 cc. It is about 97 per cent saturated. One hundred per cent inhalation at atmospheric pressure raises this to approach 100 per cent saturation. This means an increase of 1.7 volumes per 100 cc. in simple solution plus 0.5 volumes combined with the hemoglobin or a total of 21.7 volumes. This is an 11 per cent increase in available oxygen. If one assumes a slowing of the capillary circulation through the tumor tissue, up to 4.8 volumes per cent more could be available. This was admirably discussed by Evans.^{2,4} The nasal catheter produces in the region of 40 per cent alveolar concentration of oxygen, more than twice the normal volume. This has been shown by Kory, et al. to be a relatively efficient method of administration.⁵

4. The oxygen effect has been shown by Berry and Andrews to be enhanced in low specific ionization radiations in a response ratio of almost 3 to 1. Orthovoltage and supervoltage therapy machines thus seem to have an advantage if combined with 100 per cent oxygen even at atmospheric pressure, provided adequate dosage is delivered to the diseased tissue. The arterial O₂ content increases by about 2 more volumes per cent for each atmosphere increase in pressure.¹

Conclusions

A. *Points believed to be in favor of 100 per cent oxygen at atmospheric pressure when compared to hyperbaric oxygen.*

1. Anesthesia is never needed.
2. No contraindications or morbidity.
3. No expensive specialized personnel or equipment needed, such as two sets of chambers to accommodate a volume of patients.
4. Availability in all hospitals now.
5. An increase approaching 11 per cent in arterial oxygen becomes available by breathing 100 per cent oxygen at atmospheric pressure and an appreciably higher percentage is gained when passage of blood is slowed through diseased tissues.⁴
6. An excess of O₂ over adequacy has been shown to be of no value.⁴
7. Vessels cut at surgery contribute to anoxia in the operative field, therefore radiation can be justifi-

fiably and safely started early, within two or three days, and the oxygen helps compensate for the relative wound anoxia. Radiation is also more helpful early than late in destroying residual carcinoma.

8. Many patients fare better psychologically treated locally than at distant centers.

9. Compton scattering is greater in treating through a gas under pressure.

B. Points believed to be in favor of 250 Kvp therapy:

1. In low specific ionization radiation, the oxygen effect has been shown by Berry and Andrews, and by Gray to be enhanced in a response ratio of almost 3 to 1, when compared to therapy with accelerated particles heavier than electrons.¹

2. In bone lesions, the selective increased absorption by bone is considerable at lower energies.

3. Energy is lost by going through the perspex window of the oxygen chamber. This loss amounts to 15 per cent with telecobalt therapy.

4. Availability now in community hospitals. Even in the urban areas only about one third of the hospitals including some of the larger ones, have supervoltage facilities.

It is not our aim to minimize the undeniable advantages of supervoltage treatment on deep seated lesions or of hyperbaric O₂ on many diseases including tumors, but if there is any merit to the above limited observations we believe they are worth verifying by others.

Summary

1. Observations are reported on a plan to solve the problem of recurrence of malignant nodules in the treated area of postmastectomy patients.

2. An increase in the region of 11 per cent or more in the O₂ tension of relatively anoxic tissue is gained when 100 per cent oxygen at atmospheric pressure is inhaled by nasal catheter. This selectively

increases the sensitivity of anoxic tumor tissue to radiation. Its modes of action are briefly reviewed.

3. Over a five year period only one recurrence was noted in 42 consecutive patients inhaling 100 per cent O₂ at atmospheric pressure during treatment by orthovoltage, as compared to a 43 per cent recurrence rate in a similar control series over the four years immediately prior to this added modality.

4. Orthovoltage and supervoltage methods of radiotherapy combined with atmospheric and hyperbaric O₂ are reviewed in relation to the problem of the prevention of local recurrence.

5. The above limited evidence is believed to be sufficient to warrant verification by others.

Acknowledgment and thanks are given to Drs. J. Robert Andrews, National Cancer Institute, Bethesda, Maryland 20014; H. S. Van Ordstrand, Cleveland Clinic, Cleveland, Ohio 44106; I. Churchill-Davidson, St. Thomas Hospital, London, S.E. 1; C. L. Sarin, National Heart Hospital, London, W 1, England; and Milton Oppenheim, Director of Anesthesia, Woman's Hospital, Cleveland, Ohio 44106, for their helpful criticism and suggestions and to those surgeons on our staff whose referrals made this survey possible.

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SENILE BREAKDOWN.—A group of 72 individuals exhibiting evidence of personal and environmental lack of hygiene and deterioration in social standards was studied over a period of four years. The incidence was of the order of 0.5 per 1,000 population over 60. Most of the patients were over 70 years old, and women far outnumbered men. Isolation, a certain type of personality, bereavement, and alcoholism were found to be important factors in causation. Slightly over half the patients showed psychotic symptoms.

There is often a positive rejection of society and resistance to offers of help. It is suggested that the condition may be considered as a syndrome.—Duncan Macmillan, M. D., and Patricia Shaw, M. D., Nottingham: *British Medical Journal*, 2:1032-1037, October 29, 1966.

Low-Protein (Giovannetti) Diet In Chronic Renal Failure

Description of the Special Diet and Illustrative Case Report

WARREN W. SMITH, M.D.

FOR SOME TIME, there has been uncertainty about the usefulness of dietary protein restriction in chronic renal failure. The renowned Addis himself seemed to be confused in this matter: on one hand, he argued that a high protein intake required the already impaired kidneys to work harder to excrete the greater amount of urea; but in another part of the same book¹ he said, "We can make what [renal tissue] remains grow larger and more effective by giving a high protein diet."

The patient with uremia generally must undergo so much discomfort, deprivation and discouragement, that the clinician, mindful of the frequent dissociation between blood urea level and symptoms^{2,3} is naturally reluctant to add unpleasant dietary restrictions unless he is convinced that definite clinical benefit will result.

During the past several years, in Europe and in England,⁴⁻¹¹ a special type of low protein diet has been studied and found to be of outstanding benefit for most patients with chronic uremia. Results with this diet have also been reported orally in this country by Merrill¹² but there has been little about it in the American literature. It is the purpose of this communication to describe this diet and its effects in one patient personally observed.

Essentially, this diet consists of limitation of the protein to a daily allowance of about 20 grams of *high biologic value*, i.e., high in percentage of essential amino acids, plus careful attention that sufficient calories are provided for energy needs. Once the patient with uremia becomes "established" on this diet, his gastrointestinal symptoms disappear and the blood urea concentration falls. The symptomatic benefit is so dramatic that little coaxing is required to keep the patient on the diet.

There is no limitation of foods free of protein. Dietary sodium is limited only if otherwise indicated for the treatment of hypertension or edema. The allowed protein is taken in the form of hen eggs and milk, which provide protein of the highest bio-

The Author

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logic value. Foods containing "second-class" proteins — meat, fish, cheese, and ordinary flour — are forbidden. A special protein-free flour is used for preparation of bread, cookies and cake. Details about the diet are recorded in the Appendix.

Case Report

The usefulness of this diet is exemplified by the following case. A 54 year old white woman with polycystic kidney disease (demonstrated at laparotomy in 1959), was admitted to Riverside Methodist Hospital on March 4, 1966, with intractable nausea and vomiting (see Fig. 1). She had had no symptoms of kidney disease until the year before, when she began to have fatigability, anemia requiring transfusions, and, during the month prior to admission, nausea and vomiting.

At the time of admission she was seen to be a pallid woman appearing chronically ill, who interrupted the examination frequently with vomiting. She was slightly obese, but free of orthopnea and edema. The blood pressure was normal. Large kidneys were easily palpated in the abdomen.

Admission laboratory studies included: hemoglobin 8.7 Gm./100 ml.; plasma creatinine 12.8 mg./100 ml.; blood urea nitrogen (BUN) 120 mg./100 ml.; sodium 138, potassium 4.2, chloride 112, CO₂ 14, calcium 5.3 and phosphorus 7.9 mEq/liter. Chest x-ray and electrocardiogram were normal. Endogenous creatinine clearance was 4.6 ml./min.; subsequent determinations yielded values around 5 or 6 ml./min. The urine volume was abundant, averaging 2 liters per 24 hours. The day after admission, the BUN was 129 mg./100 ml., and on that day a six-hour hemodialysis was performed with the Kolff twin-coil artificial kidney. At the end of the dialysis, the BUN was 29 mg./100 ml. After dialysis, gastrointestinal symptoms cleared and she felt comfortable except for mild fatigability.

The patient continued to feel fairly well during the next five months, except for fatigability which was largely attributed to anemia, and which was treated with transfusions to keep hemoglobin in the 6.5 to 7.5 grams/100 ml. level. During this time, she took a routine "40 gram protein diet" as prescribed by the hospital dietitian. For several months, the BUN was fairly constant in the 80 to 90

Submitted October 25, 1966.

Reprint requests to 1211 Dublin Road, Columbus, Ohio 43212.

Pt. B.H.
54 y.o. wh ♀
POLYCYSTIC KIDNEYS
C_{creat} 5-6 ml/min

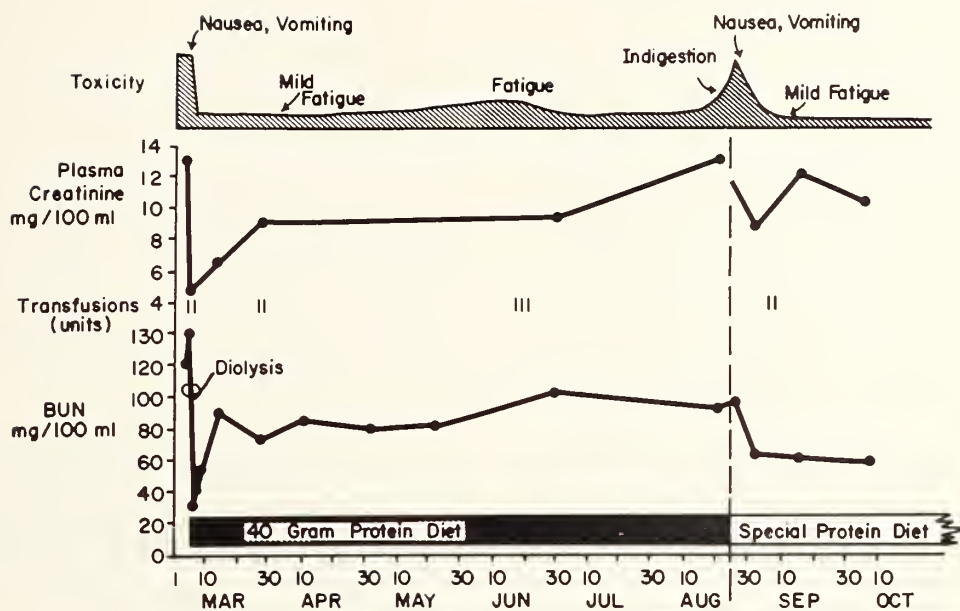


FIG. 1. Illustrative case of patient with polycystic kidney disease and uremia treated with conventional "low-protein" diet and then special low-protein diet. For details, see text. At time of correction of galley proof (Dec. 19, 1966) BUN was 48 mg./100 ml.

mg./100 ml. range. The BUN was 100 mg./100 ml. on July 1st.

In late August 1966, she noted return of indigestion, followed by nausea with occasional vomiting, although the BUN was no higher. On August 26 the "special protein diet" was introduced with protein in the form of hen eggs and whole milk to amount to approximately 22 grams per day. Within several days, gastrointestinal symptoms cleared, and, on her next visit, September 2, the BUN was found to have fallen to 64 mg./100 ml. To the time of this writing (October 30, 1966), the BUN has remained in the low 60's, and the patient has remained virtually free of digestive symptoms. Plasma creatinine levels did not change significantly. She does not find the diet difficult to follow, although she does miss the appetite-satiety value of meat. She has exhibited no tendency either to waste or accumulate salt and is allowed to take salt according to her taste. Her body weight is practically the same—145 plus or minus 4 lbs.—as when first seen, in March 1966.

Comment

This patient developed nausea and vomiting due to "uremia" as a result of polycystic kidney disease. She was much benefited by a single hemodialysis. When gastrointestinal symptoms returned five and one-half months later, she was shifted to the special protein diet: the gastrointestinal symptoms disappeared as the BUN fell from 100 mg./100 ml. to below 60 mg./100 ml. The need for repeat hemodialysis has been postponed. Despite the fall of BUN, plasma creatinine is substantially unchanged.

Mechanism of Benefit

It is as yet uncertain through what means this diet is beneficial (even as it is unknown what biochemical

derangements are responsible for the uremic syndrome). There is, however, good evidence¹¹ that when a uremic patient takes this diet, his metabolic processes may utilize urea in the resynthesis of amino acids and proteins. This is suggested by the appearance of N¹⁵ in the proteins and amino acids of azotemic patients who have been fed N¹⁵-tagged urea while taking this diet. In contrast, non-uremic subjects exhibit negligible urea utilization regardless of other dietary manipulations. This would suggest that some of the "waste" or "end products" of protein metabolism (urea, organic acids, and various substances identified and unidentified) are removed from the body pools and reformed into useful and less toxic substances.

Patients likely to respond to the diet are those who have chronic azotemia due to intrinsic renal disease, with a creatinine clearance greater than 3.5 ml./min., and a urine volume in excess of 1 liter per day.¹⁰⁻¹² It is necessary that the patient be intelligent and willing to adhere strictly to the diet—although little persuasion is needed after the first week because the patient notices a major relief of annoying gastrointestinal symptoms. It is also necessary that the patient eat the full diet every day and, in order to permit this, preliminary dialytic treatment may be necessary to relieve gastrointestinal symptoms. This diet is usually incompatible with the nutritional requirements of a diabetic patient. This diet may be—probably is—

deficient in calcium,¹³ especially in view of the known reduction in calcium absorption in uremia, and calcium plus multivitamins should be given as a supplement. Some workers⁷ advise the addition of supplementary methionine (0.5 Gm./day) and/or lysine (3-6 Gm./day).

This diet is effective in the majority of patients who fulfill the criteria listed above. In instances of intractable nausea and vomiting, Giordano¹¹ will put the patient on a protein-free diet, which is then supplemented with the respective indispensable ("essential") amino acids in amount equivalent to 8.5 Gm. protein per day, and this may bring about relief of symptoms.

Not only does the "special protein diet" relieve the gastrointestinal symptoms of the uremic syndrome, but it also changes the terminal picture of uremia in many patients taking it.⁸ The modified terminal syndrome is characterized by the rather sudden development of bleeding, agitation, and a sense of impending disaster in a patient who has been ambulatory and whose appetite has been, and continues to be, excellent. There may suddenly develop severe acidosis and hyperkalemia, and death follows within two or three days. The present author has observed another patient who experienced great relief of gastrointestinal symptoms while taking this diet, and who became terminally ill and died quickly as described above. Up to the last day of life, the patient was eager for food. It must be admitted that this mode of death is more merciful than the usual terminal syndrome of uremia.

Summary

The Giovannetti "special protein diet" herein described has been found to relieve azotemia and the gastrointestinal symptoms of uremia in well over half of the patients with chronic uremia in many clinical centers.⁴⁻¹² The essentials of the diet are, (1) provision of adequate caloric intake; (2) the elimination of second-class protein from the diet; (3) maintenance

of nitrogen balance with 20 to 25 grams of high quality (milk or eggs) protein. If the azotemia does not respond to these measures, the protein is further reduced by giving only the eight essential amino acids in amount comparable to 8.5 grams of protein per day. This diet is likely to be of benefit if the glomerular filtration rate as estimated by endogenous creatinine or urea clearance is at least 3.5 ml./min., the patient does not have a complicating "catabolic" illness, and the daily urine volume is over 1 liter. The very young, the very old, food faddists, and diabetics may not or cannot follow the diet well enough. Finally, this diet may be deficient in some vitamins and perhaps calcium and methionine, and supplementation with these is suggested.

The author is indebted to Mrs. Marcena Breth, Therapeutic Dietitian, Riverside Methodist Hospital, for her generous and expert assistance.

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APPENDIX

Instructions to Patient about Special Low Protein or "Giovannetti" Diet

The purpose of this diet is to furnish you with adequate calories for energy needs, and to limit a food constituent called protein to a modest amount of certain varieties only.

Your daily allowance of protein may be furnished by (a) 3 hen's eggs a day, or (b) 2 eggs plus 6½ oz. of cow's milk per day.

PROHIBITED: Ordinary flour, meat, fish, cheese.

You must use a special flour (which has had the protein removed) for making bread, cookies and cake.

Order MacDowell's Self-Raising Wheat Starch Flour®, for making bread, cake and cookies which have no protein. This may be ordered through Health Food Distributors, Inc., 7303 W. McNichols Road, Detroit,

(Continued)

APPENDIX (Continued)

Michigan 48221. This comes in packages of 2½ pounds costing \$1.00 each plus shipping. The following recipes should be followed for using this flour to best advantage.

WHEAT STARCH BREAD

½ lb. Self-Raising Pure Wheat Starch Flour
2 oz. Sugar
2 oz. Margarine
Milk as required — about one cup

METHOD

Sieve the dry ingredients into a bowl, rub in the Margarine, and mix in enough warm milk to make a batter consistency. Mix lightly and pour into a greased tin. Bake in a quick oven for 10 minutes, then reduce to moderate heat for a further 30 minutes.

WHEAT STARCH CAKE

½ lb. Self-Raising Pure Wheat Starch Flour
4 oz. Sugar
4 oz. Margarine
1 tsp. Salt
4 oz. Milk
1 Egg (optional)
Flavour with coconut, dates, or chocolate

METHOD

Sieve the dry ingredients into a bowl, rub in the Margarine, and mix in milk and egg if used. Bake about 30 minutes in a hot oven (400 degrees F.).

COOKIES

6 oz. Self-Raising Pure Wheat Starch Flour
4 oz. Margarine
4 oz. Sugar
1 Egg
Grated Orange Rind

METHOD

Cream together Margarine and Sugar, add the egg and orange rind, and then the Flour. Bake for about 20 to 25 minutes in a moderate oven (300 degrees F.). Makes about 30 cookies.

Vegetables Allowed

Turnip
Cucumbers
Celery
Rutabagas
Summer Squash
Vegetable Juice Cocktail
*Tomato Juice
Beets
Carrots
Eggplant
Pumpkin

Radishes
Winter Squash
*Tomato
Onions
Asparagus
Cabbage
Lettuce
Green Peppers
Parsnips
Wax Beans
Snap Beans

*Sweet Potato
Chard
Endive
Mushrooms
Dandelion Greens
Okra
Rice
*Potato
Mustard Greens
Turnip Greens

*Should be avoided if the diet is restricted in potassium.

Cereals Allowed

Corn Flakes
Hominy

Rice Krispies

Cream of Rice
Puffed Rice

Sample Menu for One Day

Breakfast	Noon Meal	Evening Meal	8 p. m.
Pear Nectar	<i>Special Vegetable Plate</i>	<i>Special Fruit Plate</i>	Lemonade
Corn Flakes	Hard Cooked Egg	Peach Halves	Lemon
Brown Sugar	Beets, Buttered	Bing Cherries	Karo Syrup
*Special Bread	Wax Beans, Buttered	Small Apple	
Butter	Baked Potato	*Special Bread	
**Milk	*Special Bread	Sherbert	
Sugar	Ginger ale	Ginger ale	
Tea	Butter	Butter	
	Jelly	Jelly	
	**Milk	**Milk	

*Special bread, cookies, or cake as prepared by foregoing instructions.

**Total day's ration of milk is 6½ ounces if only 2 eggs are taken. If 3 eggs are taken, no milk is allowed.

Further details and sample menus may be had by writing the author.

A Baedeker for Fat-Controlled Diets

I. Principles of Nutritional Treatment of Hyperlipidemia

HELEN B. BROWN, Ph.D.*, and MARILYN FARRAND, M.S.†

FEBRUARY is an appropriate month to begin a series of short articles on practical diets for controlling blood lipids. These articles belong to the "how-to-do-it" school. Hopefully, they will be of value to those who are prescribing fat-controlled diets for their patients with coronary disease and atherosclerosis, and will encourage others to use them. We plan to discuss the steps involved in adequate dietary treatment, the types of hyperlipidemia usually encountered, suitable dietary prescriptions, dietary fat composition, food products suitable for such diets and adjustment of these diets to practical everyday living conditions.

Dietary treatment of hyperlipidemia is both practical and worthwhile. There is no doubt that cardiovascular disease and atherosclerosis are closely linked with abnormal blood lipids. Sensible medical and public health measures require elimination of such risk factors as a high serum cholesterol level, excessive smoking, and elevated blood pressure. The crucial unanswered question is whether serum lipid reduction will retard or prevent development of coronary disease. The possible benefit of such reduction may be large. The American Heart Association has recommended a much more vigorous attack on the problem much earlier in the disease process than is being done at present.

The principles of nutritional treatment of hyperlipidemia are the same as for other medical treatment: ascertain the diagnosis, prescribe a suitable and safe treatment, and monitor its effect.

Diagnosis of Hyperlipidemia. In primary hyperlipidemia blood lipids are elevated consistently under ordinary living conditions. Secondary hyperlipidemia

due to diabetes, diseases of the thyroid, liver or kidney are ruled out. Conditions are also evaluated which may affect serum lipid levels temporarily; these include rapid weight changes, infection, fever or diarrhea. Diets, either prescribed or self-imposed, and certain drugs (nicotinic acid, Cytellin®, large amounts of aspirin) and hormones (cortisone, testosterone, estrogens, ACTH or thyroid preparations, both D- and L- forms) may affect lipid levels. If these factors are not considered, there is danger of missing a habitually high lipid level or of diagnosing hyperlipidemia incorrectly. It is also important to realize that even though blood lipid levels may be low from six weeks to two months after a heart attack, they may not remain low after the patient has returned to relatively normal activity.

Diagnosis of primary hyperlipidemia requires two or three serum lipid determinations. From our experience, we consider that hyperlipidemia is present when cholesterol is consistently above 300 mg. per 100 ml. or when triglycerides are above 200 mg. The presence of lipemia in a fasting sample indicates a high triglyceride level. Any one abnormal lipid level warrants further investigation. Abnormal serum lipid patterns will be discussed in the next Heart Page.

The Diets. Fat-controlled diets are a safe way to maintain reduced blood lipid levels for many years. In fact, diets for reducing blood lipids can be easily adjusted to treat additional conditions simultaneously, such as obesity, hypertension, diabetes and gastric and duodenal ulcers. This adaptability is an important aspect of a diet for wide use. Fat-controlled diets are those in which the amount and kind of fat are regulated. All diets suitable for reducing serum lipids are low in saturated fat. There are two kinds of low saturated fat diets: the *low-fat diet* and the *vegetable-oil food pattern*. These diets are nutritionally adequate in all respects. They contain from 12 to 16 per cent of calories from protein, or 60 to 80 grams in a 2000 calorie diet. The *low-fat diet* has about 70

The Heart Page is a periodic feature of *The Journal* containing brief, practical comments on subjects of immediate importance to practicing physicians. The comments are solicited by the Professional Education Committee of the Ohio State Heart Association.—Ed.

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per cent of calories from carbohydrate; the *vegetable-oil food pattern*, 48 per cent.

In the American diet, 40 per cent of calories is derived from fat, or 90 to 100 grams in a 2000 calorie diet. Most of this fat comes from animal products, the remainder from hydrogenated and untreated vegetable oils (Fig. 1). All fats are restricted in the *low-fat diet* to 25-30 grams, half animal fat and half from low-fat foods. The *vegetable-oil food pattern* is the low-fat diet supplemented with highly unsaturated vegetable oil, equal to the total fat contained in the American diet. Our second article will describe the use of these diets with various types of hyperlipidemia; their dietary fat composition is given in the third article and suitable food products in later Heart Pages.

Monitoring Treatment. It is important to follow the patient's progress after he has been instructed in the diet. Serum lipid levels should be determined monthly for the first three months, and at three month intervals thereafter. Body weight should be recorded, dietary instructions reviewed, and adjustments made to everyday living requirements.

The combined efforts of the physician and a properly trained dietitian will result in effective dietary treatment. By using her services, as discussed in the fourth Heart Page, advice and guidance are provided with a minimum amount of the physician's time and effort.

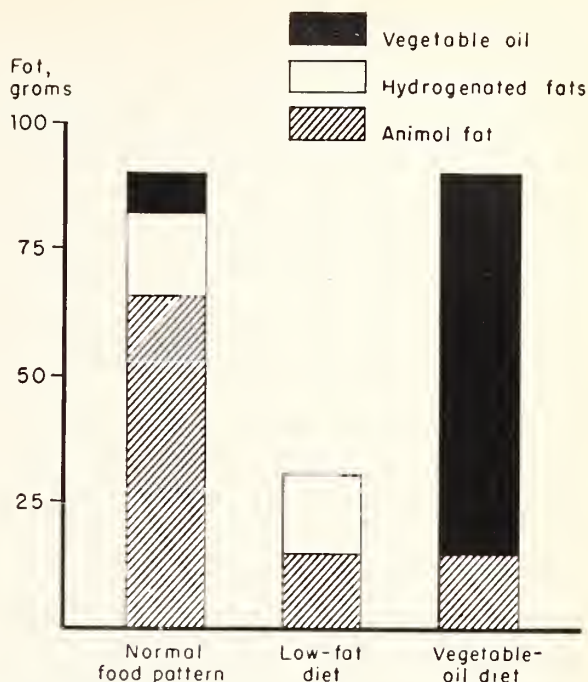


FIG. 1. Graph showing the amounts and kinds of fat in normal, low-fat and vegetable-oil 2000 calorie diets. Reprinted through the courtesy and with the permission of the author and publishers. (From Brown, H. B.: Diet and Hypercholesteremia, *Cleveland Clinic Quarterly*, 25:191-196, 1958).

TRAFFIC ACCIDENTS.— From comparatively scanty information, an increased traffic accident risk appears to be associated with several chronic medical conditions including alcoholism, cardiovascular disease, epilepsy, diabetes and mental illness. Further study probably will show that medical handicaps other than alcoholism are a factor in from 5 to 10 per cent of traffic accidents. However, in about half of the accidents caused by heart attacks, the individual has no previous knowledge of his illness, and prevention of the accident would not be possible. A selective program for identifying high risk drivers with medical conditions is feasible and warranted, but a program of mass medical examinations for all drivers is not.

A very strong relationship has been shown between drunk driving and traffic accidents, and 50 to 75 per cent of all severe and fatal traffic accidents involve the use of alcohol. However, studies have shown that drivers with alcoholism rather than social drinkers represent the preponderance, but not the entirety, of those who get into trouble. A major reduction in the traffic accident toll may thus depend on the early identification and treatment of alcoholism.— Julian A. Waller, M.D., M.P.H., Berkeley, Calif.: *California Medicine*, 105: 197-200, September 1966.

A Clinicopathological Conference

From The Ohio State University Hospital, Columbus, Ohio

Edited Under the Auspices of the Ohio Society of Pathologists

J. B. McMILLAN, M. B., Ch. B., *President*

PRESENTATION OF CASE

A WHITE boy, aged 16, was transferred from another hospital with a chief complaint of abdominal pain. Three weeks before the admission to University Hospital he developed coryza and a cough productive of small amounts of yellow sputum. Otherwise he felt well and had no chills, fever, or chest pain. The symptoms persisted for several days, and his local physician gave him an injection of penicillin, which did not relieve the coryza and cough. One week prior to his admission to University Hospital he awakened in the morning with nausea. He was anorexic, and during the day he developed pain in the left lower quadrant of the abdomen and in the suprapubic area. This pain was described as dull, constant, and accompanied by intermittent cramps. That evening the pain was more intense and he began to vomit bile-stained material. The following day his pain was more severe and he vomited each time he took food or liquids.

He was admitted to the local hospital, where he was maintained on intravenous fluids and given analgesics and penicillin. Gastroduodenal examination, barium enema, and intravenous pyelograms were reported as normal. On different occasions during his week's stay in the local hospital the left knee, left ankle, and both elbows became swollen and painful. The joints were warm and his right arm was reported as twice as large as normal. He had nocturia, slight dysuria, and moderate tenesmus. On the day of his transfer he had a bowel movement containing bright and dark blood.

The patient lived on a farm, drank well water, but had had no exposure to toxins.

Physical Examination

At the time of admission his pulse rate was 112 per minute, temperature 99.4°F. (oral), respiratory rate 22 per min., and blood pressure 170/100. During his hospitalization his systolic pressure varied between 150 and 190 and the diastolic pressure between 100 and 120. The patient appeared acutely ill and was writhing and crying with abdominal pain.

Presented by

- Neil Thomford, M. D., Columbus, and
 - Emmerich von Haam, M. D., Columbus;
- Edited by Dr. von Haam.

The skin was moderately dehydrated and described as "tight." The pharynx was moderately injected but without exudate. "Shotty" lymph nodes were present in both axillary and inguinal areas and small tender nodes in the neck. The lungs were clear to percussion and auscultation. The heart had a sinus tachycardia, and a grade 1, short, blowing systolic murmur was heard at the apex. The valve sounds were normal, and there was no cardiomegaly.

The abdomen was not distended. Bowel sounds were hypoactive and barely audible. There was diffuse tenderness to palpation with moderate guarding. The point of maximal tenderness was over the left rectus muscle midway between the umbilicus and pubis. Both direct and referred rebound pain was present at this point. No masses or organs were palpable. There was no costovertebral angle pain, no visible peristalsis or fluid wave. On rectal examination there was marked tenderness to palpation of the peritoneum. No masses were felt. Blood, both bright and dark, was noted on the examining finger. There were no hemorrhoids or fissures. The genitalia were normal.

The right elbow was slightly edematous and tender. The biceps and forearm muscles of both arms were tender, as was the left calf muscle. All peripheral pulses were full. There were no splinter hemorrhages. The neurological examination was within normal limits.

Laboratory Examinations

The hemoglobin was 13.6 Gm, the hematocrit 43 per cent; the leukocyte count was 17,200 with 84 per cent neutrophils (70 per cent segmented forms), 7 per cent lymphocytes, and 9 per cent monocytes. The corrected sedimentation rate was 5 mm. in an hour. The urine was yellow and slightly cloudy,

Submitted November 23, 1966.

the specific gravity 1.020, the pH 5.5; it contained 640 mg. of protein per 100 ml., 2 to 4 hyaline casts, 12 to 15 white blood cells and 3 to 5 red blood cells per high power field, and 3 plus bacteria. The prothrombin time was 64.3 per cent of normal. The total protein was 5.4 Gm./100 ml. (albumin 3.2 Gm.). The serum amylase was 37 units. The blood urea nitrogen was 22 mg., the creatinine 1.7 mg./100 ml. The alkaline phosphatase, cephalin flocculation, thymol, and the serum electrolytes were within the range of normal. The catecholamine was 0.5 mcg./mg. of creatinine. The latex fixation test and brucella, typhoid, and paratyphoid agglutinin tests were negative. Three blood cultures and one urine culture yielded no growth. The electrocardiogram showed sinus tachycardia and was otherwise normal.

On roentgenographic examination the heart, lungs, and mediastinum were within normal limits. Supine and upright films of the abdomen showed mild distention of the small bowel with considerable barium remaining in both the small and large bowel from a previous upper gastrointestinal series performed at his initial hospitalization. A few small fluid levels were present in the small bowel loops. The conclusion was a minimal small bowel obstruction or a mild reflex ileus, particularly of the upper small bowel loops.

Hospital Course

On the second hospital day his temperature remained at 100°F., the pulse rate 80 to 90 per minute, respiratory rate 20 per minute. He was given 3,000 cc. of intravenous fluids containing penicillin. He had five loose, bloody stools. Approximately 50 cc. of slightly cloudy, bloody fluid was obtained by paracentesis; the fluid contained no bile and no organisms were grown on culture. The amylase was 14 units, the total protein 4.4 Gm. On sigmoidoscopy, boggy edematous mucosa was reported from 12 to 22 cm. His abdominal complaints and findings remained essentially unchanged except that he had minimal epigastric pain with nausea but no vomiting. His leukocyte count fell to 12,000, and repeated roentgenograms of the chest and abdomen were unchanged.

On the third hospital day intravenous fluids were continued and the patient was given a clear liquid diet. He vomited all ingested food and attempts at alimentation were abandoned. He continued to have diarrhea with blood-tinged stools. The pain pattern was essentially unchanged except that he had several episodes of severe cramps. His temperature was essentially normal and his pulse remained below 100/min.

During the fourth hospital day his nausea became more constant. The cramping abdominal pain increased in frequency and severity. His temperature remained normal but his pulse increased to 110-120. He had no stools and developed slight abdominal

distention. His white blood cell count rose to 25,600 with no change in the differential count; his hemoglobin and hematocrit remained stable. On this day roentgenograms of the abdomen demonstrated distended small bowel loops in the left upper abdomen with fluid levels on the upright films. A barium enema was done. The barium filled the colon and terminal ileum without evidence of obstructive lesions. The ileum showed increased diameter and a tapering of the plicae semilunaris with changes of the mucosal pattern suggestive of some form of ileitis. These studies were interpreted as showing: (1) changes suggestive of upper jejunal obstruction; (2) possible ileitis or ileocolitis. In the afternoon of the fourth hospital day an operation was performed.

CLINICAL DISCUSSION

DR. THOMFORD: We have before us a 16 year old boy with arthritis, G. I. symptoms, low-grade fever, hypertension, and marked albuminuria. Since the hypertension and the albuminuria may have been residuals of a pre-existing disease, I felt most safe to start with the arthritis and the G. I. symptoms. It seemed unlikely that he had a congenital, traumatic, or neoplastic disease, and at his age a degenerative disease would be uncommon. It also seemed unlikely to me that he had a disease caused by bacteria although I briefly considered rheumatic fever. However, he did not have subcutaneous nodules nor did he have erythema marginatum, his EKG was normal, and his sedimentation rate was normal. I dismissed subacute bacterial endocarditis also since he did not have an enlarged spleen or petechiae, since fever was not a prominent part of his illness, and his blood cultures were negative. Of course, he had had penicillin, which may have influenced the cultures. I also ruled out trichinosis, bacillary dysentery, and *Salmonella* infection.

Primary G. I. Disease?

My differential diagnosis then included diseases of unknown etiology and those of hypersensitivity. It seemed that the organ most severely involved in this case was the G. I. tract. However, I could not definitely decide whether his disease was primary in the G. I. tract with systemic manifestations, or whether he had a systemic disease the most severe manifestations of which were in the G. I. tract. Two of the primary diseases of the intestine which might produce these G. I. symptoms and can be associated with arthritis are regional enteritis and ulcerative colitis. If it were ulcerative colitis I would have expected a higher fever perhaps, with this severe disease, and also rectal tenesmus and perhaps more diarrhea. Also his barium enemas were reported as normal. If it had been regional enteritis, I would have expected a past history suggesting a G. I. disturbance. Also, arthritis is rare in regional enteritis, and the distal ileum as viewed

with a barium enema was not constricted. A normal terminal ileum is compatible with regional enteritis; however, it is rare, but in the early stages of the disease the terminal ileum need not show the classical string sign or even ulceration.

Systemic Disease with Angiitis

I decided at this point that it must be a systemic disease with severe gastrointestinal manifestations, and I then included the renal disease and the hypertension as being a part of the picture rather than pre-existing. The differentiation at this point then became one of a vasculitis or hypersensitivity angiitis, and the diseases I considered were lupus erythematosus, scleroderma, rheumatoid arthritis, polyarteritis nodosa, Henoch's purpura, drug reaction to penicillin, Wegener's granulomatosis, and of course acute glomerulonephritis.

It seemed that all of these were capable of producing the symptoms, physical signs and laboratory findings that this boy had, but I ruled out systemic lupus erythematosus first, since the age and sex seemed wrong. It occurs primarily in females and the usual age is 20 to 40. Also anemia and leukopenia are reasonably common findings in this disease. Along the same lines I ruled out scleroderma. There again the age and sex seemed wrong to me, since it occurs primarily in females ages 30 to 50, and the onset is ordinarily not as abrupt. Acute glomerulonephritis almost invariably has hematuria, and I might have expected some azotemia or edema. Certainly the abdominal pain is consistent with acute glomerulonephritis because it is often in the flanks, is colicky, but the abdominal symptoms do not ordinarily become as severe as they did in this boy.

Rheumatoid arthritis is capable of having an associated vasculitis involving the intestine, and although this is not common it may lead to severe G. I. symptoms. However, in rheumatoid arthritis the sedimentation rate is almost always elevated. If this were a drug reaction to penicillin, producing a serum sickness type of syndrome, I would have expected perhaps pruritus and some urticarial lesions with swelling of the eyelids, lips, or face. Eosinophilia would also be very common if this were a drug reaction. Wegener's granulomatosis is a necrotizing granulomatous disease of unknown etiology which may have severe gastrointestinal and renal manifestations. However, the hallmark of this disease — the necrotizing granulomas of the upper respiratory tract — seemed absent although he had had some upper respiratory symptoms.

Henoch's purpura is a disease which commonly follows the administration of a drug or a minor infection. It is a disease of children and young adults, and occurs most often in the male. It is an allergic disease with alterations in the small blood vessels, and although purpura is usually present it need not be present at the onset of the gastrointestinal and renal symptoms and may appear later or

not at all. Joint symptoms of course are common with Henoch's purpura, as is a periarticular edema. With the renal involvement in Henoch's purpura hypertension may occur.

Polyarteritis nodosa commonly begins with, or is perhaps precipitated by, a drug reaction or a minor infection such as an upper respiratory infection. It is one of the so-called collagen diseases. It often begins with fever, myalgia, abdominal pain, often has hypertension, and a severe vasculitis in the intestine may produce mesenteric infarction. Frank arthritis, however, is uncommon in polyarteritis nodosa as opposed to myalgia. The sedimentation rate is almost always elevated in polyarteritis nodosa, and eosinophilia and anemia are common.

Polyarteritis Nodosa or Henoch's Purpura

I concluded, after looking over all these diseases, that polyarteritis nodosa and Henoch's purpura were the most likely, and in attempting to choose between these two I looked more carefully at the course of the disease and the pathology eventually produced, since the mechanism of the production of gastrointestinal and joint symptoms in these two diseases is somewhat different. As I mentioned, in terms of the joint findings, a myalgia is perhaps more common in polyarteritis nodosa, and the findings in this boy — the swellings described about his joints and in his forearm — seem more consistent with Henoch's purpura. The bleeding from his gastrointestinal tract may have been caused either by ulceration of the mucosa produced by polyarteritis nodosa, or it might have been produced by the submucosal or mucosal hemorrhages in Henoch's purpura. However, I thought the boggy rectal mucosa was more consistent with the diagnosis of Henoch's disease than with the vasculitis of polyarteritis. This boggyess may have been the result of submucosal hemorrhages and edema seen in Henoch's purpura and it often extends throughout the gastrointestinal tract.

If the blood in the peritoneal cavity two days prior to operation was the result of mesenteric infarction with polyarteritis, then I believe the patient should have been more ill at the time it was found. I think perhaps the blood in the peritoneal cavity again would be more consistent with peritoneal purpura such as one might have in Henoch's disease. The colicky abdominal pain, suggestive of mechanical small bowel obstruction, which was supported by the x-ray findings, was due to mechanical small bowel obstruction by the hemorrhage. May we see the x-ray pictures now, please?

Discussion of X-Ray Studies

DR. DUNBAR: The mucosa of the entire colon is edematous and nodular. The terminal ileum is dilated, and there is extreme thickening of the transverse colon, perhaps best seen in this loop right here. I think this would deserve the description

of a stack of coins, which is now linked radiologically most frequently with intramural hematoma. The radiological diagnosis was acute ileocolitis. However, I don't think you could possibly have a small-bowel wall like this with ulcerative colitis, whether or not you see ulcers within the colon. The other thing it could have been was regional ileitis with superimposed extensive granulomatous colitis. I think in the light of our present knowledge about intestinal infarctions that this film is quite diagnostic of extensive intramural hemorrhage throughout the entire small bowel and possibly the colon, although I don't think the colon changes are quite as diagnostic.

Intramural Hematoma of Small Bowel

DR. THOMFORD: The colicky abdominal pain which was suggestive to the physicians in charge of the patient as being due to small bowel obstruction was probably caused by a large intramural hematoma in the small bowel with intussusception and obstruction, and I feel that this colicky abdominal pain was certainly more consistent with Henoch's purpura than with polyarteritis nodosa. The fact that the colicky pain tended to wax and wane over a period of a week or ten days was also more consistent with Henoch's purpura. Therefore I have arrived at a diagnosis of Henoch's purpura with severe G. I. and renal involvement, and I presume that the patient had a submucosal hematoma which gave rise to intussusception.

He had also massive albuminuria, if we can interpret the one specimen as being characteristic of the amount of protein he was losing. Since massive proteinuria would be a little unusual, one might postulate a hemorrhage about, or thrombosis of, one of the renal veins contributing to the albuminuria of his renal disease and allowing it to become massive in proportion.

General Clinical Discussion

DR. PRATT: May we ask what the operation was that the patient was subjected to?

DR. MARABLE: I guess that's fair. Would you like to speculate about what the operator found, Dr. Thomford?

DR. THOMFORD: In order to go along with my diagnosis, I would expect that on opening the abdomen the surgeon found free bloody fluid, purpuric lesions in the peritoneum, and very boggy edematous intestine with submucosal hemorrhage and edema. If an intussusception was present, then I would expect it was reduced. If there was a definite hematoma at the leading point of this intussusception I would expect that resection might have been necessary. If intussusception did not exist at the time of operation, then I would presume that nothing was done other than perhaps muscle and skin biopsies of any nodule or node that was present.

Description of Surgeon's Findings

DR. MARABLE: I may say that at the operation there was indeed bloody fluid in the peritoneal cavity. There was evidence of an intense inflammatory reaction with extension over the entire ileum and to a lesser degree over the colon. There were two or three short areas of the ileum that were not so extensively involved, but the vast majority of the ileum was described by the operator as "more or less uniformly involved in this intense inflammatory response with increased vascularity of the mesenteric fat." The bowel was described as having the feel of a garden hose in many areas due to the thickening of the wall. There was no intussusception. The involved area of the small bowel was resected, the terminal ileum was closed, and an end-to-end transverse colostomy was done. At the operating table one of these diseased areas in the ileum was opened and no lumen could be appreciated at all.

DR. THOMFORD: That agrees with my prediction. What about his postoperative course?

DR. MARABLE: His postoperative course was rather prolonged. He developed frequent gastrointestinal hemorrhages, which went on for about a month, and he received 23 units of blood during this period. His blood urea nitrogen rose steadily until it reached 196 mg. at the time of death. His hypertension and proteinuria continued and on the tenth postoperative day he had his first convulsion. Following this he developed jaundice and became progressively lethargic, oliguric and hypotensive, and died.

CLINICAL DIAGNOSIS

1. Massive intramural intestinal hemorrhage due to Henoch's purpura or polyarteritis.
2. Acute intestinal obstruction with possible intussusception.
3. Massive proteinuria due to renal involvement.

PATHOLOGICAL DIAGNOSIS

1. Polyarteritis of small intestine.
2. Subacute glomerulonephritis.
3. Acute scleroderma.

DISCUSSION OF PATHOLOGY

DR. VON HAAM: The autopsy showed a combination of lesions all of which fall within the group of collagen diseases. While the true classic forms of the various collagen diseases still exist, more and more frequently we are finding mixed forms which are hard to classify. This may reflect either different types of injury or different effects in various individuals depending upon which of the collagen systems is more sensitive or more vulnerable. Additional complicating factors are the effects of therapy and the varying survival periods of the patients.

The specimen removed at surgery was a very hemorrhagic, swollen section of ileum and showed extensive areas of hemorrhages, some involving the

mucosa and submucosa while others involved the entire wall and even extended into the adjoining mesentery. There was also present severe edema which produced a rigidity of the entire bowel with marked stenosis of the lumen. The microscopic section showed an involvement of various-sized vessels by thrombi in various stages of organization, with a severe inflammatory reaction and all the changes in the vessel wall typical of polyarteritis.

At the autopsy the boy appeared very emaciated and showed a dry, scaly skin which showed numerous brownish area of induration. The heart was small. The microscopic section showed numerous areas of calcification of myocardial fibers accompanied by a mild inflammatory reaction. The vessels of the lung contained multiple thrombi, some of which were calcified. The esophagus showed a marked submucosal fibrosis as is typical in acute scleroderma. The peritoneal cavity contained a purulent exudate suggesting that the patient died from peritonitis. The remaining portion of the bowels showed lesions similar to those observed in the surgical specimen.

Many arteries showed destruction of their walls with the formation of small aneurysms. The spleen was moderately enlarged but did not show the changes typically found in collagen diseases. The liver showed areas of necrosis of the ischemic type. The gallbladder was partially infarcted, with the vessel changes typical of polyarteritis. The pancreas showed no vascular lesions. Extensive hemorrhagic lesions were found in both adrenal glands with deposition of calcium in the necrotic areas. The kidneys appeared large and hyperemic. The glomeruli

showed the changes typical of subacute glomerulonephritis with crescent formation and adhesions between the tuft and Bowman's capsule. The kidneys did not show the vascular lesions observed in the intestinal tract, nor did they show the changes encountered in lupus.

Sections through the skin showed various stages of scleroderma with obliteration of the sweat glands and swelling of the collagen. Again hemorrhages and areas of calcification were found in the subcutaneous tissue. The brain showed numerous microinfarcts and punctate hemorrhages.

Conclusion and Debate

In conclusion then, we have a very interesting case of a collagen disease which involved primarily the vessels of the mesentery and small intestine. In addition, the patient had a severe glomerulonephritis which accounted for his protein loss and his uremia. The ultimate cause of death appears to be a tossup between uremia and septicemia.

DR. CUPPAGE: I believe that the kidney changes fit well with Henoch-Schönlein purpura, while scleroderma can be recognized in the esophagus and skin, and polyarteritis nodosa involved the gastrointestinal tract and the brain. To bring all the lesions under one head, I would suggest hypersensitivity angitis as the correct diagnosis.

DR. SCARPELLI: The deposition of calcium in the thrombi, the heart muscle, the adrenal, and the skin has been known to exist in the group of hypersensitivity diseases. It occurs without hypercalcemia and without parathyroid lesions.

MEDICAL EDUCATION AND PRACTICE.—The real problem in medical education is whether clinical medicine should be taught as a technical discipline, or whether it should revert to a series of apprenticeships designed to cover the complete range of professional activity, and to provide a comprehensive experience. In fact, the vast increase of medical knowledge has determined the issue, and medical schools have already been forced to concentrate upon what Thomas Lewis called theoretical as opposed to vocational training, and to aim at a rational understanding of disease rather than a particular preparation for practice.

The difficulties of achieving this objective are constantly underrated or tacitly ignored. The generally didactic character of preclinical teaching often leaves students singularly unprepared for clinical work. Many are still waiting to be taught and are not yet ready to learn by making accurate observations for themselves. Those who watch their progress closely commonly find that they take at least a year to acquire a sound clinical technique only to lose it again after the rather disconnected tour of the special departments which usually follows the initial period of ward work. — Alastair Hunter, M. D., F. R. C. P., London, Eng.; *British Medical Journal*, 2:552-557, September 4, 1965.



NEWS AND *Organization Section*

Proceedings of The Council...

Matters Considered and Actions Taken at Meeting Held in
Columbus, December 10 and 11; Approved Budget for 1967

A REGULAR MEETING of The Council of the Ohio State Medical Association was held in the headquarters office, Columbus, December 10-11, 1966. All members of The Council were present except Dr. Robert C. Beardsley, Zanesville, Councilor of the Eighth District. Others attending were: Mr. Wayne E. Stichter, Toledo, legal counsel; Mr. David B. Weihaupt, Chicago, AMA Field Representative; Mr. James S. Imboden, Columbus, Field Representative, American Medical Political Action Committee; Dr. John H. Budd, Cleveland, Chairman, Ohio delegation to the American Medical Association; Dr. H. T. Pease, Wadsworth, alternate delegate to the AMA; Dr. Anthony Ruppersberg, Jr., Columbus, Chairman, OSMA Committee on Maternal Health; Dr. William T. Washam, Columbus, Secretary, State Medical Board; Mr. Charles H. Coghlan, Columbus, Executive Vice-President, Ohio Medical Indemnity, Inc.; Messrs. Page, Edgar, Gillen, Traphagan, Campbell, and Moore of the OSMA staff.

New Developments

President Meredith opened the meeting with a discussion of the following developments:

1. Results of the November 8 elections.
2. The rescinding of requirements for the civil rights pledges and agreements.
3. The work of the Ohio delegation, officers, and staff at the AMA midyear session of the House of Delegates.
4. The overwhelming endorsement by county medical societies of the OSMA direct billing policy.
5. Heavy legislative duties being anticipated in 1967.

6. The appointment of Dr. Crawford to the Ohio State Medical Board.

7. The centennial session of the Geauga County Medical Society.

8. Comments with regard to a publication of the AMA Department of Governmental Medical Services, Division of Socio-economic activities, dated November, 1966 (Volume 1, No. 4).

Minutes Approved

The minutes of the meetings of The Council held September 10-11, October 23 and 26 and November 1, 1966, were approved by official action.

Membership Statistics

The following membership statistics were accepted for information: OSMA membership as of December 9, 1966 was 10,075, compared to a total membership of 10,033 on December 9, 1965 and 10,042 on December 31, 1965. Of the 10,075 members, 8,990 were affiliated with the AMA.

Reports by Councilors

The Councilors reported on developments and activities in their respective districts.

Opinion on Fee Arrangements

The Council issued an interim report regarding the propriety of a proposed arrangement involving certain professional medical services provided in a hospital. Dr. Smith was authorized to provide the information contained therein to appropriate physicians in his Councilor District. Following is the text of the report:

"The Council has been asked to comment on the propriety of a proposed arrangement involving

certain professional medical services provided in a hospital, the fee for which is now paid for by a hospital service contract.

"It is our understanding that the proposed arrangement provides for the physician to submit directly to the patient his usual and customary fee for his professional medical services and voluntarily file, with each hospital in which he practices, a statement of his usual and customary fees which may, on his own initiative, be changed from time to time.

"At the same time, the hospital would submit to Blue Cross a memorandum in the amount of such physician's professional fee as indicated by a statement of his usual and customary fees then on file. The physician, to our understanding, does not participate in the formulation of the memorandum. Blue Cross then would issue, to the patient, a check in the amount of the fee.

"The Council, to give a formal opinion, would find it necessary to have before it any such proposed agreement by the parties involved, in writing and in specific detail. The Council: (1) reiterates and reaffirms the opinion of the House of Delegates of the Ohio State Medical Association (Am. Sub. Res. 8, 1963 and Sub. Res. 19, 1965) that payment for such professional services should not be included in a hospital service plan, and (2) urges continuous effort and cooperation on the part of all hospital-based physicians in the effectuation of this policy.

"Informally, The Council points out that its approval or recognition of any arrangement whereby Blue Cross pays for a professional medical service might erroneously be construed as endorsement of an existing condition which The Council and the House of Delegates view with deep concern; namely, inclusion of professional medical services in Blue Cross contracts. Council's approval of such a billing arrangement also might be interpreted as an invitation to expand coverage of professional medical services until the entire spectrum of medicine is written into Blue Cross contracts.

"Blue Cross is a hospital service plan. Hospitals cannot lawfully engage in the practice of medicine. The Ohio Attorney-General has held (Opinion 1751) that hospitals cannot legally engage in the practice of medicine. This opinion states, in part:

"'4. A hospital corporation, whether or not organized for profit, is entitled to a fair compensation (a) for the use of technical equipment owned by it and used by a physician in the performance of professional services, and (b) for nonprofessional services supplied to such physician; but, where such corporation enters into an arrangement with a physician whereby it receives compensation for such use and such services which is manifestly in excess

of the fair value thereof, the hospital is unlawfully engaged in the practice of medicine and the physician is guilty of grossly unprofessional conduct under the provisions of 1701.03, Revised Code of Ohio.'

"In regard to the request for Council's opinion, Council will state officially this Association's policy regarding direct billing, namely, that physicians should bill directly all patients, regardless of what arrangement the patient may have with a third party; and

"The term 'direct billing' means and is hereby defined as the preparation of a separate bill for professional services on the physician's own letterhead (or billhead), addressed to the patient (or the member of the patient's family legally responsible for payment of such services), and mailed or delivered to the patient, **without** any notice to, or understanding with, either the hospital in which the professional services were rendered or the patient that:

"(1) The patient has no responsibility for the payment of such bill and may ignore it, or

"(2) the patient may relieve himself of his responsibility to the physician for payment by (a) transmitting such a bill to the hospital in which the professional services were rendered, or (b) transmitting such bill to an organization or carrier which provides coverage to such hospital for hospital services as distinguished from professional services."

Medical Assistants

The Council approved a communication from Dr. Richard L. Fulton, Columbus, chairman of the Advisory Committee to the Ohio State Society of Medical Assistants, with regard to the problem resulting from the absence of a charter for one of the county affiliates.

Dr. Fulton said that proper organization of the Summit Society of Medical Assistants should be accomplished as expeditiously as possible . . . and expressed the hope that such can be successfully completed by March 1, 1967.

Dr. Fulton also advised the society of The Council action, giving the Ohio State Society of Medical Assistants \$1,000 to help defray expenses for the national meeting of the organization in California next year. These funds have to do with ceremonies in connection with the inauguration of an Ohio member, Mrs. Margaret Swank, Newark, as president of the national organization.

Report on AMA Meeting

Dr. Budd, Chairman of Ohio's AMA delegation, reported to The Council on the midyear session of the American Medical Association, November 27-30, 1966, in Las Vegas. (See Dr. Budd's report on what disposition was made of resolutions introduced by the

Ohio delegation, and other information about the AMA session, beginning on page 234.)

Financial Report

The Council, in executive session, then considered a report of the Committee on Auditing and Appropriations, presented by the chairman, Dr. William R. Schultz, Wooster. The report of the committee, including a budget for 1967, was approved by official action.

BUDGET FOR 1967

The Ohio State Medical Journal	\$ 42,000.00
Organizational Staff Salaries and Expenses	49,305.00
Stenographic and Clerical Salaries	68,995.00
President: Expense \$4,500;	
Honorarium \$4,000	8,500.00
President-Elect: Expense \$3,500;	
Honorarium \$2,000	5,500.00
Council, Expense	10,000.00
American Medical Association Delegates- Alternates	17,300.00
Department of Public Relations (\$49,032.00)	
Salaries and Expenses	36,532.00
Public Information	500.00
Health Education and Exhibits	500.00
Postage	3,500.00
Supplies	500.00
Miscellaneous Activities	7,500.00
Committees:	
Education	\$ 800.00
Judicial and Professional Relations	600.00
Public Relations and Economics	400.00
Scientific Work	2,000.00
Auditing and Appropriations	1,270.00
Cancer	350.00
Disaster Medical Care	600.00
Environmental and Public Health	1,000.00
Eye Care	300.00
Government Medical Care Programs	2,000.00
Hospital Relations	1,500.00
Laboratory Medicine	400.00
Maternal Health	1,800.00
Medicine and Religion	150.00
Mental Health	1,200.00
Rural Health	1,400.00
School Health	1,500.00
Workmen's Compensation	500.00
Annual Meeting	30,000.00
Conference of County Medical Society Officers	3,000.00
Councilor District Conferences	4,500.00
Emergency and Equipment Fund	6,000.00
Employees' Retirement Fund	6,513.00
Insurance, Bonding, Social Security	15,720.00
Lectures for Junior Medical Students	3,500.00
Legal Expense	14,000.00
Library	300.00
OSMAgram	7,500.00
Postage	3,500.00
Professional Relations Activities	19,000.00
Rent	21,465.00
Rural Medical Scholarships	4,000.00
Stationery and Supplies	6,000.00
Telephone and Telegraph	6,500.00
Office: Huntington Bldg., Equipment	2,700.00
Total	\$422,600.00

Committee Reports

Judicial and Professional Relations — Mr. Page presented a report of the Judicial and Professional Committee, based on the minutes of a meeting held November 20, 1966. The report included discussion of a program to meet the problem of malpractice claims and the appointment of a subcommittee to study the matter.

The committee reviewed communications from Dr. John D. Porterfield, Director of the Joint Commission on Accreditation of Hospitals, and with Dr. James G. Roberts, President of the Summit County Medical Society, concerning staff appointments and hospital privileges. It recommended no additional action at the present time. The minutes were approved.

Athletic Injuries — Mr. Edgar presented a report of the Joint Advisory Committee on Athletic Injuries, based on the minutes of a meeting held November 2. The committee proposed a complete survey of football injuries sustained by Ohio scholastic football players; announced August 16, 17, 1967 as dates for the Athletic Injury Postgraduate Institute; and set up regional athletic injury conferences for coaches for the Spring of 1967. The report was approved.

Government Medical Care Programs — The minutes of the meeting of the Committee on Government Medical Care Programs held October 19, 1966 were presented by Mr. Traphagan. It was pointed out that the committee proposes to operate through a group of subcommittees, each subcommittee dealing with specific government programs. The minutes of the committee were approved.

Subcommittee on Aid for Aged, Blind, Dependent Children, and Disabled, of the Committee on Government Medical Care Programs, met November 30, 1966 and requested that The Council of the Ohio State Medical Association take appropriate steps to inform County Medical Society legislative chairmen that these chairmen should make contact with the members of the Ohio House and Ohio Senate regarding legislative support for an increase in the budget of the Ohio Department of Welfare to the end that 100 per cent of the physician's usual and customary fee may be paid to reimburse welfare recipients. This action was approved.

The Subcommittee on Demonstration Health Facilities recommended to The Council that a representative (practicing physician) from each County Medical Society included in the plan of the Ohio Valley Health Service Foundation, Inc., be a member of the Board of the Ohio Valley Health Service Foundation and that, in the future, any areas engaged in Demonstration Health Facility Planning include at the top level of organization, a representative (practicing physician) from each County Medical

Society involved in the plan. Such recommendation was approved.

Joint Committee on Family Practice — Mr. Edgar presented the minutes of a meeting of the Joint Committee on Family Practice held October 26, 1966. The committee recommended to The Council that the Ohio State Medical Association endorse the report of the AMA's Citizens Commission on Graduate Medical Education, known as the Millis Report, and the report of the Ad Hoc Committee on Education for Family Medicine of the AMA Council on Medical Service.

The committee also made a definitive statement with regard to the training of professional personnel and ancillary medical personnel in emergency and definitive techniques of closed chest cardiopulmonary resuscitation. The committee was of the opinion that such training be approved provided that: (1) The instructors shall be physicians. (2) Trainees shall have completed, as a minimum, advanced, comprehensive courses in first aid techniques. (3) Hazards of such techniques shall be emphasized. (4) Periodic refresher courses shall be required.

The Council approved the report as a whole.

Environmental and Public Health — Mr. Gillen presented the minutes of a meeting of the Committee on Environmental and Public Health held November 16, 1966. It was reported that Dr. Emmett W. Arnold, Director of the Ohio Department of Health, discussed with the committee the problems of water pollution control, solid waste disposal, and air pollution.

Mr. Robert Youngerman, secretary of the AMA Committee on Quackery, appeared before the Committee on the subjects of quackery and chiropractic.

Dr. Tennyson Williams reported on the National Symposium on Immunization which he attended as a representative of the OSMA on October 17, 1966, in Atlanta, Georgia. On behalf of the committee, Dr. Williams will develop a suggested immunization schedule to be used with schools and health departments and to be used as a guide in the office of the practitioner.

The committee will give consideration to a number of legislative proposals involving traffic safety at its next meeting.

The Council approved the report as a whole and referred to the committee a question on immunization policies submitted by the Ross County Medical Society.

Mental Health — Mr. Traphagan presented the minutes of a meeting of the Committee on Mental Health held October 9, 1966. The Council approved suggestions of the committee for amendments to the "Guidelines for Development of a Community Mental Health Act." This included the request that individual physicians providing service to patients at a community health center be given the oppor-

tunity to bill patients directly for their professional services and that the bill be on the basis of the physician's usual and customary fee. Also, that a "sliding scale" of charges be established by the Community Mental Health Center to discourage those who can afford private psychiatric care from use of the center facilities.

A statement on temporary limited licensure for noncitizen physicians was accepted for information only.

The proposal for an educational campaign involving news releases on the problem of LSD was approved by The Council.

The handbook on "Hospitalization of the Mentally Ill in Ohio," prepared by the committee, will be issued to all members of the Association early in 1967.

The remainder of the report was approved by The Council.

Insurance — Mr. Campbell presented the minutes of the meeting of the Committee on Insurance held October 9, 1966. The committee's statement on a standardized billing form was accepted for information only, since there is an overlapping with the direct billing form project presently being developed by the Association.

A statement on coordination of benefits was amended by The Council as follows and approved:

"The Committee reaffirms its position on Coordination of Benefits as expressed in a motion passed at the August 14, 1966 Committee on Insurance meeting. The motion passed at that meeting is as follows: 'The Committee doubts that multiple purchase of individual Health Insurance significantly increases the over-all cost of hospitalization. It also feels that Coordination of Benefits on individual policies denies the patient the responsibility to determine the usage of his premium dollar.' It is not the responsibility of the physician to determine and report on the existence of a patient's health insurance policy."

The Council agreed with the committee that the OSMA should not endorse any single Keogh retirement plan. It accepted the committee's suggestion that the insurance industry should be contacted in regard to a constructive information article on Keogh Retirement Plans for *The Journal*.

The remainder of the report was approved.

Laboratory Medicine — Mr. Campbell presented the minutes of the meeting of the Committee on Laboratory Medicine held October 12, 1966. In approving the report, The Council approved plans for a Conference on Laboratory Medicine at the 1967 Annual Meeting, that members of the Ohio Society of Medical Technologists be invited to attend the conference, and that the Ohio Association

of Blood Banks be invited to present an hour of the program.

The Council **approved** the forwarding of a copy of a "letter of agreement" from the Blood Service Insurance Plan to the officers of the Ohio Association of Blood Banks, to the Red Cross and to the Ohio Insurance Commissioner, pending approval of the OSMA legal counsel.

The remainder of the report was **approved**.

Workmen's Compensation — Mr. Campbell presented the minutes of a meeting of the Committee on Workmen's Compensation held December 7, 1966. It was agreed at this meeting by members of the committee and by officials of the Bureau of Workmen's Compensation that assistants to surgeons receive separate payment under the usual and customary fee concept.

The Council **approved** the committee's suggestion that cases referred by the OSMA to county medical societies for review should be followed up in six weeks after the receipt of such cases from the Bureau of Workmen's Compensation.

The Council also **approved** the recommendation that the OSMA communicate in writing to the Administrator of the Bureau of Workmen's Compensation, reiterating the OSMA policy on direct billing and asking that bills from physicians for professional services on BWC cases be paid on the usual and customary fee basis to the physicians, and bills from hospitals be paid directly to the hospitals.

Council also **approved** the committee's recommendation that the BWC refer investigated and documented cases of overtreatment and excess diagnostic procedures to the Ohio State Medical Association. The OSMA would then use the established mechanism of review now in effect for cases of suspected overcharging.

The Council amended a request of the committee and asked that the Bureau of Workmen's Compensation be requested to provide the attending physician with all BWC claim numbers.

The remainder of the report was **adopted**.

A letter from Dr. M. M. Thompson, Toledo, President of the Ohio State Radiological Society, dated October 15, 1966, with regard to the Industrial Commission of Ohio and direct billing, was received for information.

Health Resource Task Group — Mr. Campbell presented the minutes of meetings held October 11 and November 9 of the Health Resource Task Group, which has been commissioned by the governor to deal with the problem of emergency planning. Mr. Campbell was chosen to serve as secretary of the task group. Mr. Campbell's report was **accepted** for information.

Maternal Health — Dr. Anthony Ruppertsberg, Jr., Columbus, Chairman of the Committee on Maternal

Health, presented the Maternal Mortality Report for Ohio — A 10-Year Survey, 1955-1964, just completed by the OSMA Committee on Maternal Health. The Council **approved** the report with commendation to Dr. Ruppertsberg and his committee. The approval included the adoption of the following recommendations:

"1. The Committee heartily recommends that the Ohio Maternal Mortality Study be continued, with increased effort to reduce further the maternal morbidity and mortality in Ohio. Although an attitude of pride can be justified in its research and educational facets, complacency must not be entertained lest the reduced trend of maternal deaths in the 10-year survey be reversed.

"2. Educational features connected with the dedicated efforts of the Committee must be expanded. A program of information and education should continue to focus upon factors causing maternal deaths, and their prevention. More seminars, conferences, and exhibits along this vein should be planned and implemented with the support of The Council, and county medical societies throughout the state.

"3. It is recommended further, that the Chairman and Committee members renew efforts to coordinate and compare both activities and statistical data associated with the Ohio Study, with similar studies of other states. Valuable information and data obtained through mutual transfer will be of invaluable assistance in support of a program for education.

"4. Advisory functions of the Committee with The Council, Ohio Department of Health, and other selected agencies on matters pertaining to maternal health should be continued, and augmented if the need appears."

A letter from Dr. Gilbert M. Schiff, Cincinnati, with regard to rubella-testing service in Ohio was referred to the Committee on Maternal Health for study.

OMPAC-AMPAC

A report from the Ohio Medical Political Action Committee was received for information.

Ohio Medical Indemnity, Inc.

The Ohio Medical Indemnity Liaison Committee report was submitted in writing by Dr. Robert E. Tschantz, Canton. Dr. Tschantz's report was **accepted** for information.

By official action, The Council **authorized** President Meredith to appoint a nominating committee to select nominees for the Ohio Medical Indemnity, Inc., Board of Directors, such nominees to be voted on at the annual OMI stockholders' meeting in April, 1967. Dr. Meredith named: Dr. Robert N. Smith, Toledo, chairman; Dr. Richard L. Fulton, Columbus; Dr.

Theodore L. Light, Dayton; Dr. P. John Robeck, Cleveland.

Annual Meeting

A report on annual meeting developments was presented by Mr. Traphagan.

It was the decision of The Council that plaques honoring physicians who have served in the project Vietnam be presented before the House of Delegates at the annual meeting. In the case of recipients not present at the annual meeting, The Council suggested that such plaques be presented by the Councilors at county medical society meetings and that news information be released by the OSMA headquarters office on such presentations.

By official action, The Council agreed to defer the speaker expense appropriation for the meeting of the Section on Ear, Nose, and Throat until 1968.

The Council approved a one hour general session on generic prescribing, the panel to be moderated by Dr. Perry R. Ayres, with the following suggested as participants: Mr. C. Joseph Stetler, Washington, D. C., President, Pharmaceutical Manufacturers Association; Dr. James L. Goddard, Commissioner, Food and Drug Administration; and Dr. Max S. Sadove, Chicago.

With regard to the traffic safety program, it was the expression of The Council that in light of recent developments the proposal for acquiring Mr. Nader as guest speaker is not in order.

By official action, The Council decided on the Neil House, Columbus, Ohio, as the location for the "Gaslight" party to be held in connection with the annual meeting.

The Council also approved the establishment of ten cent bus service between the two Columbus hotels and the Veterans Memorial Building.

Ohio Selective Service

Mr. Edgar announced that Colonel Heber L. Minton, assistant Ohio adjutant general for the Army, has been appointed director of the Ohio Selective Service to succeed the late Colonel Raymond Clouse. He announced that Colonel William P. Richardson remains as chief of the Manpower Division.

A communication from Colonel Richardson to Dr. Drew L. Davies, chairman of the Military Advisory Committee, dated September 21, 1966, was received for information.

Charters and Amendments to Constitutions and Bylaws

Fairfield County — Changes involving the number of members for a quorum and increasing the dues of the Fairfield County Medical Society were approved by The Council.

Gauga County — The Council authorized the re-issuance of a charter to the Gauga County Medical

Society. Also, it commended the society on its centennial celebration and sent congratulations to the officers and members of the society.

Knox County — The proposed amendments to the constitution and bylaws of the Knox County Medical Society were discussed. Mr. Stichter presented a memorandum outlining suggested changes in wording, inserting the necessary words to complete the amendments proposed by the society. The Council approved the proposed amendments with the understanding that the suggested classifications and changes of wording be adopted by the Knox County Medical Society.

Dependents' Medical Care

The Council discussed a letter from Mr. E. F. Wilenborg, Executive Secretary of the Academy of Medicine of Cincinnati and Hamilton County, calling attention to the Dependents' Medical Care Form DA 1863-2, used in connection with Public Law 569, 84th Congress, the Dependents' Medical Care Act. Such form in Section 29 requires that the physician accept as full payment for his services the fee from the medical care program schedule of allowances. The Council reaffirmed the action of the House of Delegates of the OSMA in Resolution No. 21, which asks for direct billing under this program, and referred to Ohio Resolution No. 56, which was adopted by the AMA House of Delegates in June, 1966, accepting the entire Ohio resolution and adding the request that the fees be the usual and customary fee of the physician.

The Executive Secretary was instructed to communicate with the American Medical Association, asking what steps have been taken to implement Resolution No. 56 and to encourage action on this matter.

Appalachia

The Council approved the following statement of policy with regard to the proposed Southeast Ohio Appalachia Health Care Complex and instructed the staff to send copies to members of the Ohio Valley Health Services Foundation, Inc., and to the appropriate officials in Washington:

The Council pledges the wholehearted cooperation of the Ohio State Medical Association in any program intended to improve the health status of every citizen, so long as the program is developed and implemented in a manner equitable to everyone concerned and within the guidelines set forth in this statement.

In order to assure the patient of quality medical care, any health care program must function within the following principles:

1. The program must in no way restrict, impinge on or interfere with the physician-patient relationship.

(Continued on Page 232)

Many overweight patients can benefit from the appetite control provided by the sustained anorexigenic-tranquilizing action of BAMADEX SEQUELS: anorexigenic action of amphetamine; tranquilizing action of meprobamate; prolonged action through sustained release of active ingredients.

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Contraindications: Dextra-amphetamine sulfate: in hyperexcitability and in agitated prepsychotic states. Previous allergic or idiosyncratic reactions to meprobamate.

Precautions: Use with caution in patients hypersensitive to sympathomimetic compounds, who have coronary or cardiovascular disease, or are severely hypertensive.

Dextra-amphetamine sulfate: Excessive use by unstable individuals may result in psychological dependence.

Meprobamate: Careful supervision of dose and amounts prescribed is advised, especially for patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on the drug. Where excessive dosage has continued for weeks or months, reduce dosage gradually. Sudden withdrawal may precipitate recurrence of preexisting symptoms such as anxiety, anorexia, or insomnia; or withdrawal reactions such as vomiting, ataxia, tremors, muscle twitching and, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, reduce dosage and avoid operation of motor vehicles, machinery or other activity requiring alertness. Effects of excessive alcohol consumption may be increased by meprobamate. Appropriate caution is recommended with patients prone to excessive drinking. In patients prone to both petit and grand mal epilepsy meprobamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side Effects: Overstimulation of the central nervous system, jitteriness and insomnia or drowsiness.

Dextra-amphetamine sulfate: Insomnia, excitability, and increased motor activity are common and ordinarily mild side effects. Confusion, anxiety, aggressiveness, increased libido, and hallucinations have also been observed, especially in mentally ill patients. Rebound fatigue and depression may follow central stimulation. Other effects may include dry mouth, anorexia, nausea, vomiting, diarrhea, and increased cardiovascular reactivity.

Meprobamate: Drowsiness may occur and can be associated with ataxia; the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute thrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.



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2. The program must be physician-directed and medically oriented.

3. The diagnostic, treatment, and preventive factors must be determined and directed by the patient's attending physician, and by no third party.

4. The patient's desire for good medical care must be achieved through educational methods and not artificially created by a third party.

5. The determination of a patient's need for professional services must be made by the patient's physician.

6. The medical service content must serve as the core of the health care program, and all other health care services must be constructed around this core.

In keeping with these indispensable principles, The Council of the Ohio State Medical Association is seriously concerned with the following facts:

A. The guideline in Section 1, Resolution 62, of the Appalachia Regional Commission would deliver comprehensive health services to all segments of the population, regardless of economic status of the individual receiving the services. This is not realistic and is condemned in the sense that such a guideline will destroy the present concepts of the private practice of medicine.

B. The stated intent to provide comprehensive health care to the entire population is not within the intent of Congress as expressed in Section 2, Public Law 89-4. The intent expressed in this law is " * * * to assist the region in meeting its special problems, * * * " The provision of comprehensive health services to those persons who have the ability, or third party resources, to provide their own health care is not meeting a "special problem."

C. The medical services programs contemplated by Ohio Valley Health Services Foundation, Inc., must be planned, activated and supervised by practicing physicians endowed with policy-making authority, and with respect to these principles.

D. In the provision of medical care under any circumstances, the program must conform to the Principles of Medical Ethics and the Statutes of the State of Ohio.

The Council, in addition, approved the White Paper on Appalachia — 1966, submitted by the West Virginia State Medical Association. A statement from Dr. Beardsley with regard to the Appalachia program was received for information.

JAMA Medicare Article

A letter from Dr. Wesley W. Hall, chairman of the AMA Board of Trustees, to the Medical Society of New Jersey dealing with an article on Medicare and its problems for practicing physicians, which appeared in the *JAMA*, August 1, 1966, was received for information. Such letter was in answer

to protests from the New Jersey and Ohio societies concerning certain portions of that article.

State Legislation

Dr. William T. Washam, Secretary of the State Medical Board, addressed The Council concerning proposals now being considered in connection with possible amendments to the Ohio Medical Practice Act. Items for discussion were the following: temporary and limited licensure; revision of midwifery statutes; immunity provisions for State Medical Board personnel from civil suits when acting within the scope of their authority; authority for the Board to act in cases of incompetence or mental illness; fee for certification of endorsement blanks to other states; strengthening of the grounds for refusal to grant, suspend or revoke a license; increase in penalties for illegal practice; authority for injunction procedure through the attorney general's office; increase in the examination fee from \$50 to \$75; elimination of free repeat examinations; annual registration of medical doctors; and raising of the per diem allowance for the board.

The Council tentatively approved the inclusion of the above items, but expressed the opinion that this did not necessarily require all of them in legislation. The officers, legal counsel, and staff were authorized to proceed with the drafting of a bill, or bills, with the understanding that The Council have an opportunity to review a proposal, or proposals, before introduction. Dr. Crawford abstained from voting on this issue.

Heart Disease, Cancer, Stroke, and Related Diseases

A report on the November 16, 1966 meeting of the Ohio Regional Advisory Committee for Heart Disease, Cancer, Stroke, and Related Diseases was presented by Dr. Crawford. A written outline of the plan submitted by Dr. Crawford was referred to the Committee on Government Medical programs.

Ohio Administration on Aging

Dr. Crawford reported on the November 10, 1966 meeting of the Advisory Committee, Ohio Administration on Aging. He indicated there would be another meeting December 14, 1966. His report was received for information.

Communication from OAGP

A letter from Dr. B. W. Gilliotte, Zanesville, President of the Ohio Academy of General Practice, was discussed by The Council. The first item of the letter was with regard to a possible conference of various disciplines to get a uniform recommendation for Blue Shield payment of surgical benefits to include the assistant surgeon. The question was referred to the OSMA Committee on Insurance for interpretation.

With regard to a second question in the letter, asking if the Division of Aid for the Aged could

hold money in escrow so as to earn interest until the payment could be made, it was the opinion of The Council that since such money is the patient's money, under the frame of reference of OSMA policy on direct billing, a recommendation of this nature from the Ohio State Medical Association would not be in order.

OSMA Direct Billing Form Project

A proposed direct billing form project was submitted to The Council. The President was authorized to appoint a committee to make certain revisions in the material, with the method of final approval to be at the discretion of The Council. Councilors were asked to submit suggestions within the week. Dr. Meredith appointed Dr. Robeck as chairman, Dr. Westbrook, Dr. Budd, the President, President-Elect, Past President, and Mr. Stichter.

Resolution on Dr. Platter

The following resolution was adopted by The Council:

WHEREAS, Herbert Morris Platter, M. D., 1869-1966, had served the people of Ohio as Secretary of the State Medical Board of Ohio continuously from 1917 through 1965, and had symbolized throughout his life the purposes of this Association and the medical profession in promoting the art and science of medicine and the protection of public health, and

WHEREAS, Dr. Platter established milestones by:

Conducting statewide investigations into epidemics of typhoid, scarlet fever, and poliomyelitis in 1908;

Compiling the first public health code for the State of Ohio in 1914;

Establishing the first health program for the public schools in the city of Columbus, Ohio, in 1915;

Serving as President of the Ohio State Medical Association in 1932-1933;

Receiving a Certificate of Merit from the American Medical Association for his initiation of the first scientific exhibit to be shown at an AMA convention, held in Columbus, Ohio, in 1899; and

Was awarded a certificate of appreciation by the President of the United States and was awarded a bronze plaque of recognition by the Federation of State Medical Boards of the United States, and

WHEREAS, His long, abundant, and fulfilling life ended in death on November 4, 1966.

THEREFORE BE IT RESOLVED, That the Ohio State Medical Association and the physicians of Ohio again express their admiration and gratitude for Dr. Platter's outstanding leadership, guidance, and counsel, over a remarkably long lifetime of service to the public, and be it further

RESOLVED, that the Association on behalf of all its members extend to his family its sympathy and regret of his passing, and on behalf of the medical profession, express sorrow for the loss of one so dedicated to the work which he had loved and served so faithfully and well.

Belmont County Matter

A communication from the Belmont County Medical Society was received for information.

Compulsory Generic Drug Measures

A communication from Mr. C. Joseph Stetler, Washington, D. C., President of the Pharmaceutical Manufacturers Association, regarding compulsory generic drug measures to be introduced in the 90th Congress, was studied by The Council. The Council directed the Executive Secretary to thank Mr. Stetler for his analysis and to ask him to keep the Ohio State Medical Association advised of bills as they are introduced so they may be studied with reference to the OSMA legislative program.

Service for Aphasics

A letter from Dr. Aileen L. MacKenzie, Chief, Division of Chronic Diseases, Ohio Department of Health, regarding field service in speech and language for aphasics, was referred to the Committee on Environmental and Public Health.

Woman's Auxiliary

The Council discussed a communication from Mrs. James N. Wychgel, President, Woman's Auxiliary to the Ohio State Medical Association, having to do with the rental of space by the Auxiliary in the office of the Ohio Academy of General Practice. The Council decided there was no objection to the Auxiliary renting space in the office of the Ohio Academy of General Practice.

Communication from Dr. Camardese

A communication from Dr. N. M. Camardese, Norwalk, was received for study by The Council.

Huron County Matter

A communication was received from Dr. Theodore R. Ball, Bellevue, regarding the anesthesiology situation in Bellevue Hospital. It was the Council's opinion that this is a staff problem and should be solved by the medical staff, in consultation with the Huron County Medical Society.

1967 County Society Officers Conference

The Council approved the following subjects and speakers for the County Society Officers Conference, February 26, 1967, Fort Hayes Hotel, Columbus: "Ohio State Medical Board" — W. T. Washam, M. D., Columbus; "Title XIX" — Kenneth Clements, M. D., Cleveland; "Joint Commission on Accreditation of Hospitals" — Otto Arndall, M. D., Chicago; "Medicine and Political Action" — William J. Lewis,

Jr., M.D., Dayton; "Medicine and Federal Legislation" — Aubrey D. Gates, Chicago; "Medicine and State Legislation" — Hart F. Page, OSMA Executive Secretary, Columbus.

Matter Referred to Committee on Hospital Relations

A communication from Mr. Edward Willenborg, Executive Secretary of the Academy of Medicine of Cincinnati and Hamilton County, with regard to regional planning, was referred to the Committee on Hospital Relations.

Washington Visitation Program

The Council approved a visitation program proposed by the AMA Washington office through David B. Weihaupt of the AMA Field Division. Such program would supplement present legislative activities of the Ohio State Medical Association by bringing key physicians to Washington to visit with their Congressmen and Senators for the purpose of discussing legislation.

ATTEST: Hart F. Page
Executive Secretary

AMA Clinical Session . . .

Report on What the House of Delegates Did at Las Vegas Meeting; Disposition of Resolutions Introduced from Ohio; Other Reports

AT A MEETING of The Council of the Ohio State Medical Association held on December 10-11, Dr. John H. Budd, of Cleveland, Chairman of the Ohio delegation to the American Medical Association, reported on actions at the AMA Clinical Session in Las Vegas, November 27-30. Following is a summary of the report:

Dr. Budd noted that 13 reports of the Board of Trustees, the councils and committees of the AMA were available prior to the convention and that 23 were issued at the convention. In addition, 24 resolutions were available before the convention and 40 additional ones were introduced at the convention.

The Council discussed with Dr. Budd the possibility of a resolution to request that the councils and committees of the AMA meet sufficiently in advance of the midyear and annual sessions of the House so the reports may be in the delegates' packets for study as long as possible prior to the opening of the convention.

A discussion of events at the convention indicated, in the opinion of The Council, the necessity for a resolution challenging the wisdom of the present requirements of the Constitution and Bylaws for unanimous consent to permit acceptance of a "late" resolution, since this permits one man to stop a resolution.

Limits Original Jurisdiction

With regard to the work of the delegation, officers, and staff at the Las Vegas meeting, Dr. Budd pointed out that the Ohio delegation was successful in amending a report of the Council on Constitution and Bylaws, which had been approved by a Committee on Amendments to the Constitution and Bylaws, to give

the Judicial Council original jurisdiction in cases of appeals filed by applicants who allege that they have been unfairly denied membership in a component and/or constituent association . . . the council to determine the facts in the case and report its findings to the House of Delegates. The Ohio amendment, which was introduced on the floor by Dr. Meiling, would limit this original jurisdiction to cases of discrimination on the basis of race, color, etc.

Certification and Recertification

The AMA House took up the problem of certification and recertification. It adopted a resolution that the AMA advise the Department of HEW that present requirements for certification and recertification have proven highly objectionable, unnecessary, and do not contribute to the quality of medical care. The statement asked that the AMA endeavor to bring about repeal of those portions of the medicare law in which the requirement for physician certification of medical necessity appears.

Direct Billing

With regard to direct billing under Title XIX, six resolutions were introduced. The House adopted a substitute resolution presented by the reference committee, asking that the AMA strongly support amendment of the Social Security Act, including Title XIX to permit direct payment to the patient.

Ohio Resolutions at AMA Session

A summary of AMA House actions on resolutions introduced by Ohio follows:

Resolution 1 — Resolutions and Reports Deadline (requiring that resolutions be introduced 30 days in

advance of the meeting, except emergency resolutions). The Reference Committee on Amendments to Constitution and Bylaws recommended that Resolution 1 not be approved, in view of the "short interval of time existing between the meetings of some state associations and the meetings of the AMA." The Reference Committee did recommend that delegates and state associations be encouraged to submit resolutions as early as possible. The House approved the Reference Committee report.

Resolution 2 — Reference Committee Reports (to require that reference committee reports be available to the delegates at least 24 hours before the opening of the session of the House in which they are to be considered). The Reference Committee recommended that in lieu of Resolution 2 and another resolution (35) on the same subject, the timetable of future meetings of the House be rescheduled, with the first session on Sunday afternoon. The report was adopted by the House.

Resolution 16 — Billing for Professional Services (including clarification of the meaning of direct patient billing). The Reference Committee recommended that Resolution 16 be referred to the Council on Medical Service for further study, clarification and recommendations. The Committee pointed out that primarily Resolution 16 represents reaffirmation of official policy which has been "enunciated consistently and repeatedly" and quoted the resolution adopted by the AMA House in October, 1965, which indicated that fees of specialists should not be merged with hospital charges, etc. The report of the Reference Committee was adopted.

Resolution 31 — Business Meetings of the AMA House (regarding separation of the House of Delegates from the AMA scientific sessions). The Reference Committee recommended that this resolution be referred to the Board of Trustees for its consideration, in light of Report C of the Board of Trustees, which it recommended be received for information. Resolution 31 is in conformation with the Board recommendations but offers a specific proposal, namely, that the House meet in Chicago in January, 1969 instead of at the 1968 Clinical Session. The report of the Reference Committee was adopted by the House.

Resolution 36 — Definitions of Usual, Customary, and Reasonable. The Reference Committee did not present Resolution 36, but instead presented an assortment of definitions developed by the Reference Committee itself. In the House of Delegates floor action, led by Dr. Budd and supported by Wisconsin and Michigan, Resolution 36 was adopted, in lieu of the Reference Committee report. A motion by Dr. Teall, of California, attached a paragraph of comments by the Reference Committee dealing with the history of past attempts to establish a definition. The Ohio resolution, termed the "Local Option" or "States'

Rights Resolution," leaves the matter in the hands of each state, rather than to attempt a definition on a national basis.

Resolution 37 — Medical Manpower. This resolution was considered with Resolution 4, on Selective Service procedures, and Report T of the Trustees, originating in the Council on National Security. Resolutions 37 and 4 were accepted for information and Report T of the Trustees, a study of the problems in the selection of physicians for military service in light of total physicians' needs, was adopted in the acceptance of the Reference Committee report.

Resolution 48 — This resolution with regard to doing away with "slots" in the election of the Board of Trustees and holding such elections on an "at large basis," and another resolution on the same subject, were turned down by the Reference Committee. This action was upheld by the House.

Resolution 49 — Hospital-Based Physicians (urging medical staff support of hospital physicians who are displeased due to billing philosophy). The Reference Committee amended the resolution, in consultation with the AMA Legal Department, and the resolution was adopted as amended.

Resolution 65 — This resolution, asking for a House of Delegates Committee to study the Millis Report and to report to the House in June, was submitted Monday morning by the Ohio delegation. The speaker refused to permit its introduction as an emergency resolution and subsequently it failed to receive unanimous consent of the House necessary for consideration as a "late" resolution.

American Ophthalmology Association Headed by Cincinnati Physician

Dr. Barnet R. Sakler, Cincinnati, was installed as president of the American Association of Ophthalmology at its Fall annual meeting in Chicago. A founding member of the organization, Dr. Sakler has been on its board of trustees and chairman of the executive committee.

He is assistant professor of ophthalmology at the University of Cincinnati College of Medicine, was Chairman of the OSMA Section on Ophthalmology, and a member of the OSMA Committee on Eye Care.

Another Ohioan, Dr. Charles E. Jaekle, Defiance, was named second vice-president of the organization.

Secretary is Dr. Albert C. Esposito, of Huntington, W. Va.

Dr. Arthur Dobkin, president of the Akron Chapter, Arthritis Foundation, has been honored with the national organization's Distinguished Service Award.

Dr. Charles D. Feuss, discussed "Sexual Psychopaths" at the annual meeting of the Hamilton County Police Association.



Now, now, Mrs. Forsythe, we've never lost a cold patient yet.


When she's experiencing acute discomfort from cold symptoms, it's small wonder the patient becomes distressed about her condition.

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Novahistine LP is a long-acting decongestant that helps restore normal mucus secretion and ciliary activity—physiologic mechanisms which prevent infection of the respiratory tract. A dose of two tablets taken in the morning and repeated in the evening will usually keep air passages clear for 24 hours.

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A Local Cancer Committee Reports ...

Here Is an Example of What One Cancer Committee In One County Medical Society in Ohio Is Doing

EDITOR'S NOTE: Statewide reporting of medicine's program in Ohio would not be complete without an occasional intimate look at the local scene and organized medicine's role within the various counties. The following report written by Dr. A. Clair Siddall, chairman of the Lorain County Medical Society Cancer Committee, is presented as an excellent example of local activity.

THE CANCER COMMITTEE has had a year of real activity. Eight committee meetings have been held and the attendance and the interest have been very good.

The program for the year was publicized by sending two mailings to all of our county society members, by sending information to the women's organizations, the PTA groups and the churches in the county. Films on cancer of the uterus were shown to women's organizations by the American Cancer Society and this society furnished leaflets for mailings to patients. Also during the year two rounds of publicity were released in the county newspapers and the WEOL radio station cooperated by issuing spot announcements on the value of the Pap smear.

The cancer detection program this year resulted in close cooperation with the following organizations: the county Health Department, the county Welfare Department, the American Cancer Society, Elyria Memorial Hospital, St. Joseph's Hospital in Lorain, the Oberlin Clinic and the Oberlin Health Commission and Welfare Council.

At the beginning of this year the Cancer Committee adopted three objectives, namely, that it:

1. Urge all members of our county Medical Society to continue to expand their office cancer detection with emphasis on the Pap smear.
2. Urge all hospital staffs in the county to take Pap smears on admission of all adult female patients of 20 years or older who had not had a Pap smear within the year.
3. Develop a special plan whereby Pap smears could be taken on the welfare and medically indigent women in Lorain County.

We are glad to report that all of these objectives

have been achieved to some extent as reported below.

1. Our society members have taken more Pap smears on private patients than ever before. In 1965 the total number of Pap smears in the county was 16,215 while in 1966 the number increased to 18,411. Although the number of carcinoma-in-situ increased from 33 in 1965 to 66 in 1966, the number of invasive carcinomas of the cervix remained about the same, 22 in 1965 and 23 in 1966.

2. One hospital in the county, Allen Memorial Hospital in Oberlin, has fulfilled our second objective, to take Pap smears on admission of all adult female patients. This plan was initiated October 1, and to date we have found that approximately 75 per cent of these female patients have had a Pap smear within the year.

No cancer of the uterus has come to light in the 25 per cent who had no Pap smears on admission.

3. Most of our effort on the cancer committee has been directed toward our third objective, to develop a plan whereby Pap smears could be taken on the welfare and the medically indigent women in Lorain County. This became possible when we obtained federal funds through Dr. Fisher of the County Health Department and the State Department of Health. These patients are sent to the outpatient clinics of the Elyria Memorial Hospital, St. Joseph's Hospital, and the Oberlin Clinic. To date our results are as follows:

Pap smears April 1, 1966	Elyria	Lorain	Oberlin	Total
to date	181	160	60	401
Carcinoma-in-situ	3	1	0	4
Invasive Carcinoma	1	0	1	2
				<hr/> 6

All of these patients have been adequately treated to date. It is of interest to note that in the general population, one cancer of the uterus is found for every 200 women at the first screening, while in this low income group three times this number have been found. This program has not been a crash effort and will continue another year.

It is also of interest to point out that a neglected and advanced cancer of the uterus in a woman on

welfare, which cannot be cured and results in the patient's death, incurs an expense of an estimated \$12,000 to the community. Those early microscopic carcinomas, which are treated promptly, lead to a cure, for an estimated expense of \$500 to the community, and the patient, who is often a mother of several children, is saved. Therefore, it can be said that our county program has saved six lives to date, and the county has been spared a future expense of some \$69,000.

In closing I want to thank especially Mrs. Davidson, our executive secretary, for her efficient assistance, Mrs. Judy Kaiser our case worker, Dr. Schork and Dr. Sciarrotta for supervising the outpatient clinic load in Elyria and Lorain, all of the other committee members. Drs. Taylor, Grauel, Everhart, Boysen, Gray, and the advisory committee members, Dr. Riggin, Dr. Fisher, of the County Health Department, Mr. G. Prinz of the County Welfare Agency, and Mrs. Brown, of the American Cancer Society.

OSMA Executive Secretary Heads Executives' Group

Hart F. Page, Executive Secretary of the Ohio State Medical Association, was elected president of the Ohio Trade Association Executives for 1967 at the December meeting of the organization in Columbus. He served as vice-president and a member of the Board of Directors in 1966.

The 29-year-old organization is composed of executives of some 59 statewide business, trade, and professional associations, plus a number of regional groups, and is organized for the discussion of common interests and the promotion of mutual understanding.

Mr. Page succeeds Karl M. Kahler, executive assistant with the Ohio State Council of Retail Merchants. The group chose Donald B. Smith, managing director of the Ohio Trucking Association as vice-president, and Howard B. Sturgeon, secretary of the Ohio Bankers Association, as secretary-treasurer.

Elected to the Board of Directors were: E. A. Graber, executive secretary of the Ohio Dairy Products Association, and George G. Greenleaf, executive secretary of the Ohio Grain and Feed Dealers Association, Inc. Re-elected to the board were Gene L. Tosca, executive secretary of the Ohio Tobacco Distributors, Inc., and Mr. Page. All reside in the Columbus area.

The 13th annual meeting of the New Orleans Graduate Medical Assembly will be held March 6-9, with headquarters at the Roosevelt Hotel in downtown New Orleans. Physicians interested in details are invited to write Friedrichs H. Harris, M.D., Secretary, 1430 Tulane Avenue, New Orleans, La. 70112.

Do You Know? . . .

Dr. Charles L. Hudson, Cleveland, President of the American Medical Association, was member of an official delegation to the World Medical Association's 20th Annual Assembly in Manila, P. I. At the meeting he was elected to the Council of the WMA. Dr. Hudson, with the delegation, also visited areas in Southeast Asia, including South Vietnam.

* * *

Dr. Ralph M. Patterson, professor of psychiatry at Ohio State University College of Medicine, and Dr. Rudolf Kaelbling, associate professor of psychiatry, are coauthors of a new book, *Eclectic Psychiatry*, published by Charles C. Thomas Company.

* * *

Dr. George J. Hamwi, professor and director of the Division of Endocrinology and Metabolism at Ohio State University, was chairman of the Committee on Professional Education which presented the program for the 1967 Clinical Conference of the American Diabetes Association in Dallas, Texas. Dr. Harvey C. Knowles, Jr., professor of medicine at the University of Cincinnati, was on the program.

* * *

Dr. Richard B. Stoughton, Cleveland, was elected to the board of directors of the American Academy of Dermatology at the organization's recent meeting in Bel Harbour, Florida.

* * *

Stanley A. Ferguson, director of University Hospitals in Cleveland, has been elected chairman of the Council of Teaching Hospitals of the Association of American Medical Colleges. The Council, founded in 1965, consists of representatives from 300 hospitals that either are affiliated with medical schools or maintain nationally accredited intern and residency training programs.

* * *

Dr. Beverly B. Lafferty, West Union, is featured in the 1966 edition of *Outstanding Young Women of America*, an annual sponsored by business and professional women's organizations of the nation. Dr. Lafferty practices medicine in the Adams County community with her husband, Dr. William W. Lafferty.

* * *

Dr. John J. Phair, professor of preventive medicine at the University of Cincinnati College of Medicine, has accepted appointment as Cincinnati health commissioner. He fills the position left vacant when Dr. Kenneth Macleod resigned to accept an appointment as health commissioner of Worcester, Mass.

5¢



BEER IS BACK

DURING THE OSMA ANNUAL MEETING
AT

The Gaslight Party

THURSDAY, MAY 18
7:00 P.M. 'til . . . ?

THE NEIL HOUSE
41 SOUTH HIGH STREET
COLUMBUS



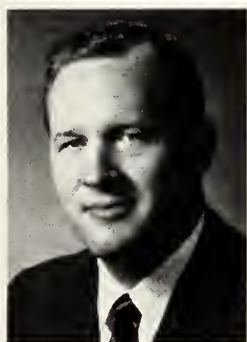
HELP KEEP THE STRENGTH IN THE PROFESSION'S

STRONG RIGHT ARM

Attend . . .

THE OHIO MEDICAL POLITICAL ACTION COMMITTEE LUNCHEON

TUESDAY, MAY 16
Celestial Ballroom
Sheraton-Columbus Hotel



Congressman
Ashbrook

The Honorable JOHN M. ASHBROOK

CONGRESSMAN
SEVENTEENTH OHIO DISTRICT

will speak on . . .

The Role of the Physician in Politics

11:45 A.M. Cash Bar

12:15 P.M. Luncheon

1:00 P.M. "OMPAC Hits the Bull's Eye"—
A Progress Report

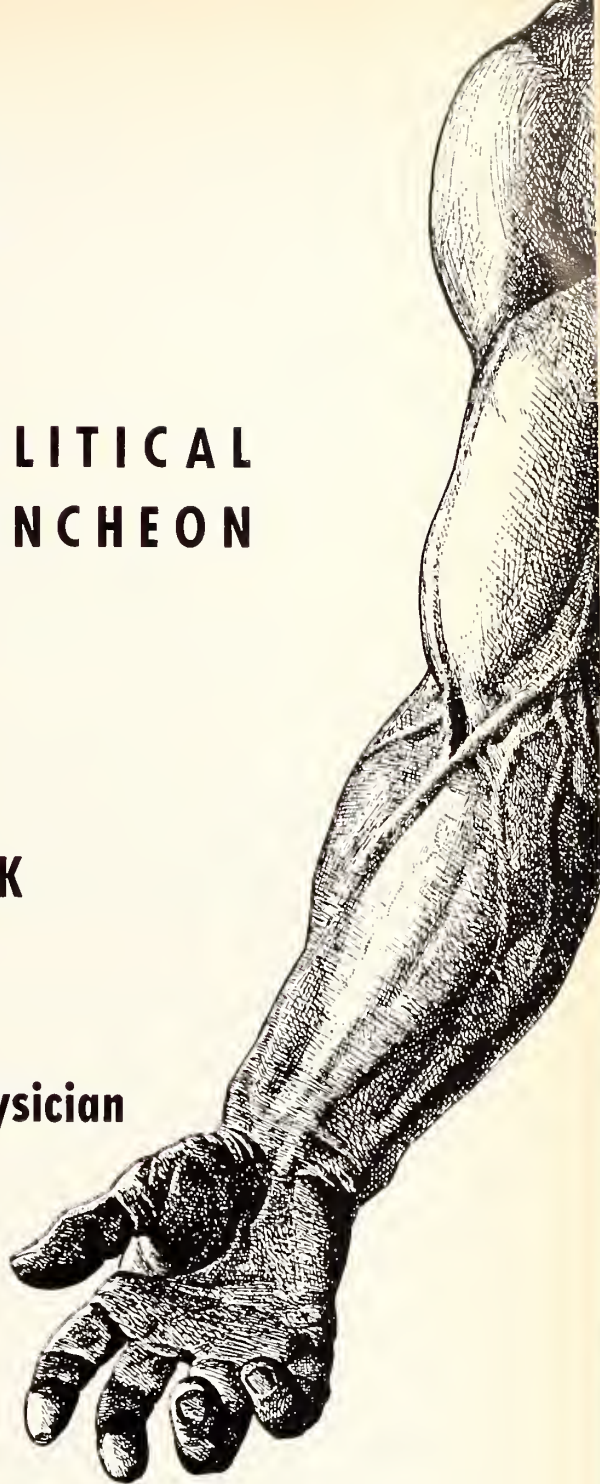
1:15 P.M. The Role of the Physician in Politics
Hon. John M. Ashbrook

Congressman Ashbrook will speak about why it is important for *all* physicians to be active in politics and will explain the role active physicians played in a successful campaign.

TICKETS . . .
\$5.00 per person

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The Ohio State Medical
Association



**TOMORROW'S
MEDICINE TODAY!**



Highlights

THE OHIO STATE MEDICAL ASSOCIATION'S

1967 ANNUAL MEETING

MAY 15-MAY 19 • COLUMBUS

Sheraton-Columbus
Motor Hotel

Veterans Memorial
Building

WEDNESDAY, MAY 17

1:30 P.M.

Main Auditorium, Veterans Memorial Building

GENERAL SESSION

"EDUCATING PATIENTS ABOUT SEXUAL RELATIONSHIPS"

Featuring

"Sexual Attitudes and Sexual Problems in Medical Practice"

MARY S. CALDERONE, M.D., New York City
Executive Director, Sex Information and Education Council
of the United States

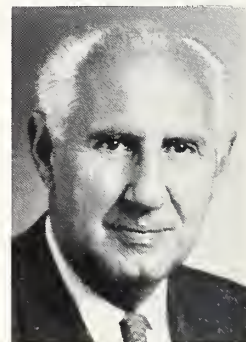
and

"Contraceptive Problems in Medical Practice"

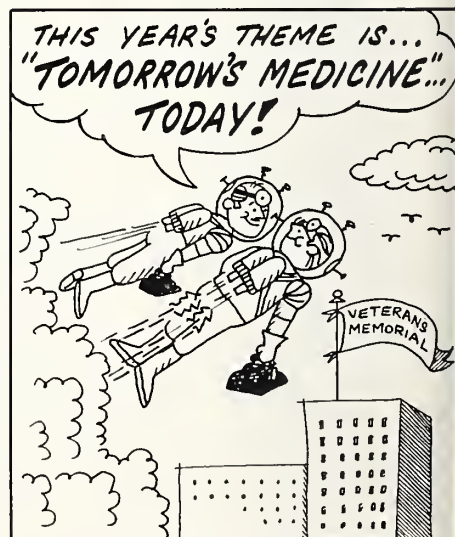
ALAN F. GUTTMACHER, M.D., New York City
President, Planned Parenthood Federation of America, Inc.



Dr. Calderone



Dr. Guttmacher



THURSDAY, MAY 18

1:30 P.M.

GENERAL SESSION

Main Auditorium

Veterans Memorial Building

"DRUG REGULATIONS AND COMPULSORY GENERIC PRESCRIBING"

A PANEL DISCUSSION

Moderator

PERRY R. AYRES, M.D., Columbus, Editor, The Ohio State Medical Journal

The Participants

JAMES L. GODDARD, M.D., Washington, D.C., Commissioner, Food and Drug Administration, Department of Health, Education, and Welfare.

MAX S. SADOVE, M. D., Chicago, Illinois, Professor and Head of the Department of Anesthesiology, University of Illinois Research and Educational Hospitals; Professor and Head of the Division of Anesthesiology, University of Illinois College of Medicine.

C. JOSEPH STETLER, Washington, D. C., President, Pharmaceutical Manufacturers Association.

FRIDAY MAY 19

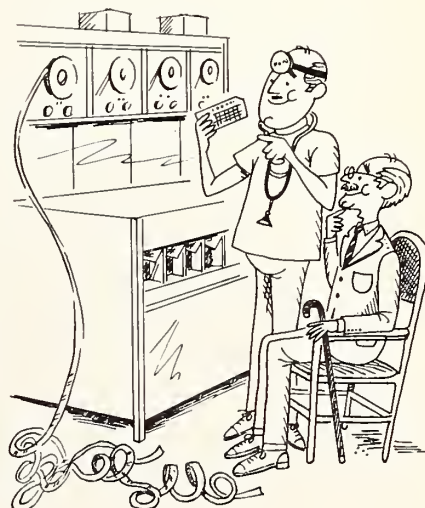
11:00 A.M.

Assembly Hall, Veterans Wing, First Floor
Veterans Memorial Building

"COMPUTERIZED AND AUTOMATED MEDICINE"

C. A. CACERES, M. D., Washington, D. C., Chief, Instrumentation Field Station, Heart Disease Control Program, Division of Chronic Diseases, Department of Health, Education, and Welfare.

MORRIS F. COLLEN, M. D., Oakland, California, Director, Medical Methods Research, The Permanente Medical Group.



FRIDAY, MAY 19
1:30 P.M.

GENERAL SESSION

Main Auditorium, Veterans Memorial Building

Featuring...

MILFORD O. ROUSE, M. D.

Dallas, Texas

PRESIDENT-ELECT

THE AMERICAN MEDICAL ASSOCIATION



Dr. Rouse

Alice Stone Woolley Memorial Lecture At OSMA Annual Meeting

The Alice Stone Woolley Memorial Lecture of the American Medical Women's Association will be delivered at a General Session during the 1967 Annual Meeting of The Ohio State Medical Association, May 15-19 in Columbus.

Mary S. Calderone, M. D., New York City, Executive Director of the Sex Information and Education Council of the United States, will present the Lecture on the subject, "Sexual Attitudes and Sexual Problems in Medical Practice." The Lecture will be presented at a General Session devoted to the topic, "Educating Patients About Sexual Relationships," on Wednesday, May 17 at 1:30 P. M. in the Main Auditorium of the Veterans Memorial Building in Columbus.

The Lecture will be introduced by Margaret J. Schneider, M.D., Cincinnati, Immediate Past President of the American Medical Women's Association. Dr. Schneider explained the establishment of the lecture fund:

During the end of her term as president of AMWA (1944-1945), Dr. Alice Stone Woolley suffered a coronary occlusion at the annual meeting in San Francisco. She recovered sufficiently to attend the meeting in New York in June, 1946, but she died in November of that same year. To honor her as an outstanding physician and as a most active member, AMWA established an Alice Stone Woolley Memorial Fund. Dr. Theresa Scanlon was made chairman and has continued her interest in this fund up to the present.

All members were given an opportunity to contribute and by 1947 \$3,500 had been collected. It was decided that this money should be used to pay the expenses involved for a speaker, as required, for the

annual meetings. In 1961 the Alice Stone Woolley Memorial Committee recommended the formation of a standing committee to be known as the Lectureship Committee, whose duties were (1) to develop a program of lectureship for the Association, (2) to develop a roster of speakers for annual, regional, or other meetings, and (3) to provide reimbursement of speakers through an honorarium from the Association funds.

Provisions in the OSMA Bylaws Pertaining to Nomination Of President-Elect

Attention is called to provisions in the Bylaws of the Ohio State Medical Association pertaining to the nomination and election of the President-Elect at the OSMA Annual Meeting. The President-Elect and other officers are elected by the House of Delegates, meetings of which will be held during the Annual Meeting in Columbus, May 15-19.

Nominations of the President-Elect are to be made 60 days in advance of the meeting at which election takes place and information on nominations published in *The Journal*, unless these provisions are waived by a two-thirds vote of the House of Delegates. The 60-day deadline is March 20.

The part of the OSMA Bylaws pertaining to this procedure is Section 1 (a), entitled "Nomination of President-Elect."

Activities of County Societies . . .

First District

(COUNCILOR: PAUL N. IVINS, M. D., HAMILTON)

BUTLER

The Butler County Medical Society honored two of its members at the December meeting for a half-century of distinguished service in the medical profession. They are Dr. Donald M. Blizzard and Dr. Charles T. Atkinson. Because of illness neither of the recipients were able to be present at the dinner meeting and the 50-Year Awards of the Ohio State Medical Association were presented in absentia.

HAMILTON

A panel discussion on "Current Status of Organ Transplantation" was featured at the January 17 meeting of the Academy of Medicine of Cincinnati. Three guest speakers constituted the panel as follows: Dr. Ban Eiseman, professor and chairman, Department of Surgery, University of Kentucky School of Medicine; Dr. John P. Merrill, director of the Cardio-Renal Section, Department of Medicine, Peter Bent Brigham Hospital, Harvard University; and Dr. James D. Hardy, professor and chairman, Department of Surgery, University of Mississippi.

Second District

(COUNCILOR: THEODORE L. LIGHT, M. D., DAYTON)

MIAMI

Dr. Jerome Wiot, co-director of the Department of Radiology at Cincinnati General Hospital, and associate professor of radiology in the University of Cincinnati College of Medicine, was speaker for the December 6 meeting of the Miami County Medical Society in Piqua. His subject was "The Acute Abdomen."

Fifth District

(COUNCILOR: P. JOHN ROBECHER, M. D., CLEVELAND)

CUYAHOGA

The annual joint meeting of the Academy of Medicine of Cleveland and the Cleveland Bar Association was held on December 12, with a social hour and dinner at the Manger Hotel. Speaker for the occasion was Dr. Irvine H. Page, who used as his topic, "Living in a World of Science."

Sixth District

(COUNCILOR: EDWIN R. WESTBROOK, M. D., WARREN)

MAHONING

Dr. E. R. Thomas, Youngstown school physician, was the guest of honor at the December 20 meeting of the Mahoning County Medical Society. Dr. Thomas was presented the 50-year pin and certificate

from the Ohio State Medical Association by Dr. Edwin R. Westbrook, Sixth District Councilor.

At the same meeting, 29 living past presidents of the Mahoning County Medical Society were honored and were presented with past president lapel pins. They are: Drs. W. K. Allsop, W. H. Bennett, A. E. Brant, L. G. Coe, G. E. DeCicco, A. A. Detesco, W. H. Evans, R. W. Fenton, J. L. Fisher, V. L. Goodwin, C. A. Gustafson, J. P. Harvey, J. N. McCann, John J. McDonough, G. M. McKelvey, F. W. McNamara, M. W. Neidus, G. G. Nelson, John Noll, S. W. Ondash, A. K. Phillips, Asher Randell, J. M. Ranz, E. J. Reilly, Jack Schreiber, F. G. Schlecht, I. C. Smith, C. W. Stertzbach, and E. J. Wenaas.

(Since the meeting, the medical society was saddened at the death of one of the past presidents, Dr. J. M. Ranz died on December 30. He was president in 1918.)

Dr. F. A. Resch made the annual president's address and presided over the election of officers. Dr. Robert R. Fisher was elected president-elect. Dr. Harold J. Reese took office as president on January 1.

STARK

Dr. Murray W. Scott, Jr., of Canton was installed as president of the Stark County Medical Society for the year at the organization's annual meeting held December 8 in the Garden Room of the Mergus Restaurant. He succeeds Dr. A. R. Furnas, Jr., of Massillon.

Named president-elect for 1968 was Dr. William D. Baker of Alliance.

Elected secretary-treasurer was Dr. Harold Dowell of Canton.

Named as delegates to the State Association were Dr. A. S. Ahbel and Dr. T. D. Furness, both of Canton. Alternate delegates are Dr. Myrl D. Musgrave and Dr. L. C. Underwood, both of Canton.

Serving as members of the Council for the coming year are Dr. E. Joel Davis of East Canton, Dr. E. E. Grable and Dr. Jerry Newman, both of Canton, along with Drs. Scott, Baker, Furnas, and Dowell.

Three members of the Society were honored in recognition of fifty years of service in the practice of medicine. They are Dr. George S. Hackett, Dr. Paul Hofman and Dr. A. W. Warren, all of Canton.

Dr. Hackett, a graduate of Cornell University and the New York Medical College, spent several years as a resident surgeon in The London Hospital. He served in the English Medical Corps in 1916 and became a surgeon in the American Medical Corps overseas when the United States entered World War I. Most of his years of practice have been in the local area. Since his retirement, he has maintained

(Continued on Page 252)



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tients with decreased liver function, since prolongation of effect may occur.

Adverse Reactions: Idiosyncrasy, such as excitement, hangover, or pain, may appear. Hypersensitivity reactions occur in some patients, especially in those with asthma, urticaria, or angioneurotic edema.



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an active interest in his medical field and has had several papers and a book published. He has also spoken at a number of national meetings.

Dr. Hofman, born in Czechoslovakia, graduated from the University of Vienna and some years later was a member of the Medical School faculty of that university. He served in the Austrian Army in the early days of World War I and later was Medical Officer with the Czech Legion of the Allied Forces in 1917 and 1918. Dr. Hofman became a member of the Stark County Society in 1941 and has practiced in the area since that time. His hobbies are books, music and art.

Dr. Warren is a graduate of Western Reserve University School of Medicine and for a number of years was chief of staff at Mercy Hospital. He has served as President of the Board of Trustees of Muskingum College and also for several years was a member of the Board of Trustees of Westminster College. Dr. Warren's hobbies are his garden and home workshop.

The speaker for the evening was Dr. William Washam of Columbus who is Executive Secretary of the Ohio Medical Board.

SUMMIT

Dr. Leonard Vernon Phillips, of Akron, was installed as 1967 president of the Summit County Medical Society at a ceremonial dinner on January 4 in the Sheraton Hotel, Akron. The event marked the Society's 125th anniversary and the silver anniversary of the Woman's Auxiliary.

Other officers are Dr. William Rogers, secretary; Dr. D. W. Mathias, president-elect; and Dr. E. Gates Morgan, treasurer. Dr. James G. Robert, is immediate past president.—Adapted from the *Akron Beacon Journal*.

Eighth District

(COUNCILOR: ROBERT C. BEARDSLEY, M. D.,
ZANESVILLE)

FAIRFIELD

The Fairfield County Medical Society's new officers for 1967 took office at a meeting in Lancaster early in January. Dr. Andrew Essman succeeded Dr. George W. LeSar as president. Dr. John W. Edwards is vice-president, and Dr. C. Richard Reed, secretary-treasurer. Dr. Richard A. Welsh was named to the censor committee, and Dr. J. L. Kraker, was named delegate to the OSMA House of Delegates.—Adapted from *Lancaster Eagle-Gazette*.

Tenth District

(COUNCILOR: RICHARD L. FULTON, M. D., COLUMBUS)

FRANKLIN

Five local physicians were honored at the annual Christmas banquet of the Academy of Medicine of Columbus and Franklin County with the 50-Year

Award of the Ohio State Medical Association. Those present at the meeting were Dr. Roderick A. Bruce, Dr. Harry C. A. Beach, and Dr. Benjamin W. Abramson. Dr. Richard L. Fulton, Tenth District Councilor, presented the awards, while Dr. Joseph A. Bonta, president for 1966, presided at the meeting. Physicians receiving the award in absentia were Dr. Earl H. Ryan and Dr. Clarence B. Tanner.

Eleventh District

(COUNCILOR: WILLIAM R. SCHULTZ, WOOSTER)

LORAIN

Seventy-three physicians and guests attended the regular meeting of the Lorain County Medical Society on January 10 at Oberlin Inn.

A Symposium on a "Diagnostic Program for the Prevention of Rheumatic Fever" was presented by the Heart Association of Northeastern Ohio, Inc., Cleveland, in cooperation with the Society.

The panel consisted of Charles H. Rammelkamp, Jr., M. D., professor of medicine, Western Reserve University School of Medicine, Cleveland; Bernard Boxerbaum, M. D., associate professor; and Silas C. Daugherty, M. D., senior instructor, at Western Reserve University School of Medicine, Department of Pediatrics.

Dr. Rammelkamp is director of medicine and director of Research Laboratory, and Dr. Daugherty is visiting pediatrician, Cleveland Metropolitan General Hospital. Dr. Boxerbaum is chairman of the Rheumatic Fever Committee, Heart Association of Northeastern Ohio. The panel presentation was supplemented with slides, charts, and literature.

Thomas Sfiligoj, M. D., of Lorain, member of Lorain County Medical Society, presided; his office acts as a central calling number in connection with the mail-in throat culture service available to physicians without charge from the Heart Association of Northeastern Ohio. The Cleveland Metropolitan General Hospital houses the laboratory, assists with the necessary equipment, and provides direct medical supervision of the operation. The program is financed jointly with funds from the Heart Association of Northeastern Ohio and the Ohio Department of Health.

Following a vote of thanks to all who participated in making arrangements for such an interesting and effective program, President R. S. VanDervort called the business meeting to order. Ibrahim N. Eren, M. D., of Lorain, was unanimously elected to Active Membership in Lorain County Medical Society, and a first reading was heard for Antoine S. Sfeir, M. D. (Lorain), as Associate Member, and for Otto Schales, D. Sc. (Elyria), as Affiliate Member.

Several announcements were made relative to Society business, and discussion followed regarding

appointment of Utilization Committees for Extended Care Facilities.

MEDINA

Members of the Medina County Medical Society entertained wives and guests for the annual holiday event at the Rustic Hills Country Club. Committee members for the pre-Christmas dinner dance were Dr. Richard Glosch, of Lodi; Dr. C. A. McGrew, of Wadsworth; and Dr. David Mack, of Medina.

Ohio Academy of Medical History To Meet at Granville Inn

The Ohio Academy of Medical History will meet on Saturday, April 15, at the Granville Inn, Granville. The program will begin at 10:00 a.m. Persons desiring overnight accommodations should contact the Granville Inn direct.

Persons wishing to submit papers for presentations at the meeting should mail them not later than March 1. Additional information may be obtained from Genevieve Miller, Ph.D., Secretary-Treasurer, 11000 Euclid Avenue, Cleveland, Ohio 44106.

Dr. Kenneth L. Upp, Greenfield physician, has been appointed a rifle, pistol, and shotgun instructor by the National Rifle Association of America.

Rules on Smallpox Vaccination For Foreign Travel Revised

The Ohio Department of Health has forwarded to *The Journal* the following information received from the U. S. Public Health Service pertaining to the new international certificate of vaccination or revaccination against smallpox:

At its meeting in May 1965, the Eighteenth World Health Assembly adopted the recommendation of the Committee on International Quarantine to amend the smallpox vaccination certificate to indicate whether a freeze-dried or liquid vaccine was used and to include the origin and batch number of smallpox vaccine. The new certificate came into force on January 1, 1967.

To be valid for international travel, smallpox vaccinations performed after January 1, 1967 will have to be recorded on the new certificate.

Smallpox vaccination certificates issued prior to January 1, 1967 shall continue to be valid for the period for which it was previously valid.

The International Certificates of Vaccination, Form PHS-731, has been revised to include the new International Certificate of Vaccination or Revaccination against Smallpox.

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The amended Keogh plan will allow a full deduction beginning in 1968 of the pension contribution for the Owner-Employer. This tax saving plan also allows you to invest in an income tax deferred plan.

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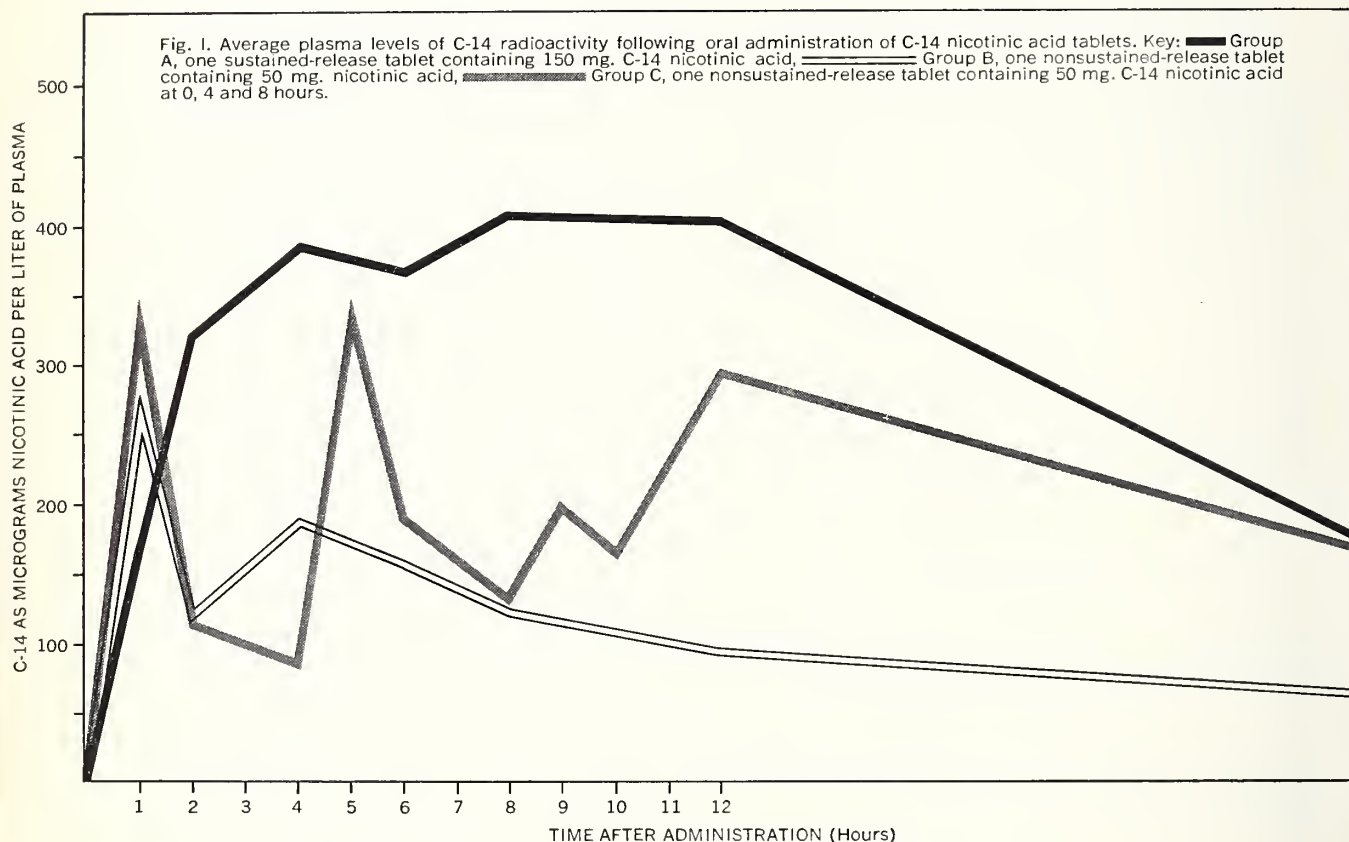
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Sustained circulatory, respiratory and cerebral stimulation for the



(fewer absent doses by
absent-minded patients)

Human volunteer subjects were administered Geroniazol TT tablets with the nicotinic acid component made radioactive with C-14. Plasma and urine samples were analyzed. (See Figures I and II) The radioactive tracer study substantiated the previous clinical evidence that the release of nicotinic acid from the Geroniazol TT tablet produced a gradual rise in plasma levels to a plateau for a total of 12 hours and more.

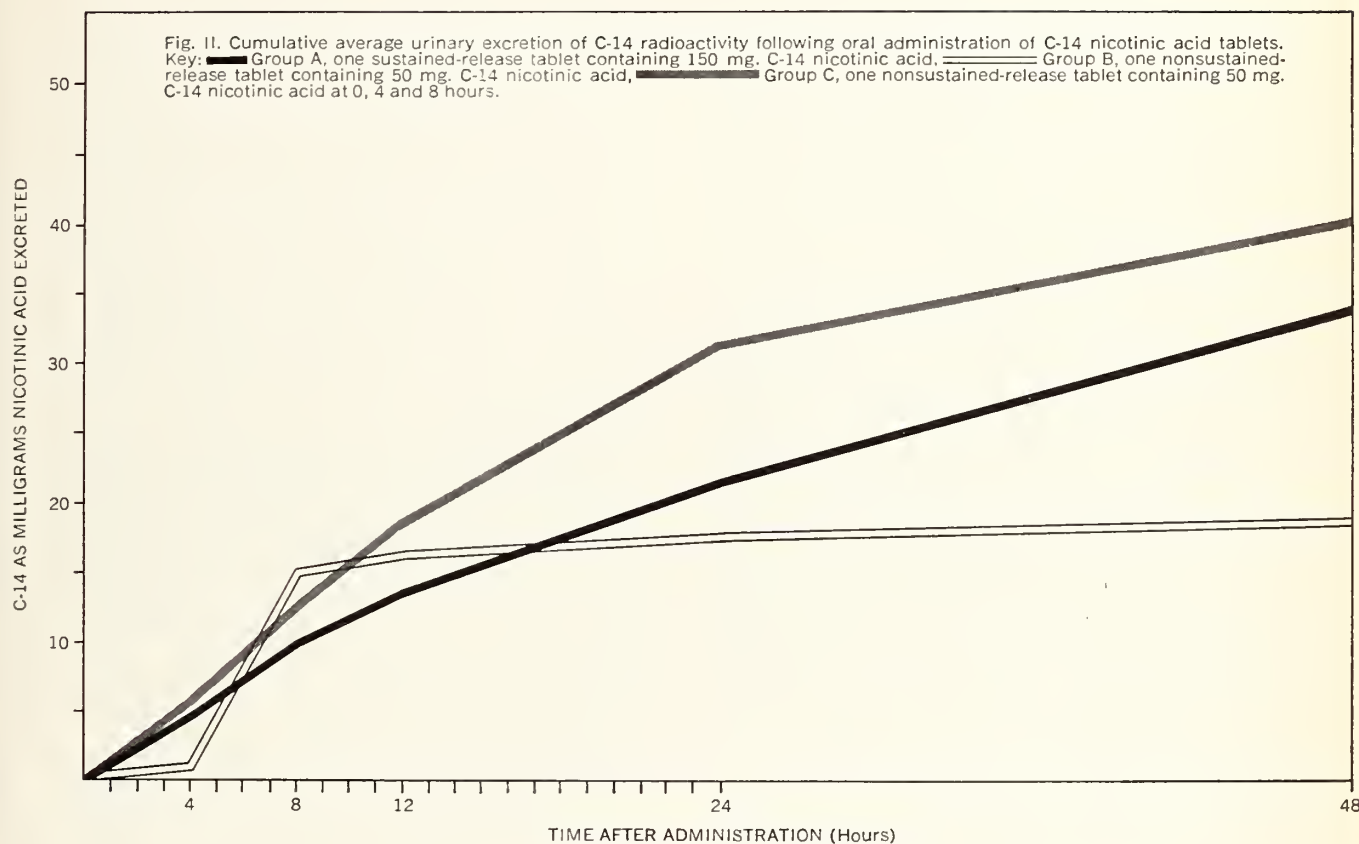
Such proven sustained activity makes the management of geriatric patients much easier by minimizing the possibility of neglected doses through absent-

mindedness or senile confusion. Therapy *can* be continuous on a daily dose of only one Geroniazol TT tablet every 12 hours.

The gradual release of nicotinic acid in Geroniazol TT will provide the well-known peripheral vasodilatation needed in patients with deficient circulation and with a minimum amount (if any) of "flushing." Also, cerebrovascular circulation is complemented by pentylenetetrazol, long-established as a cerebral and respiratory stimulant.

Geroniazol TT improves the typical, unfortunate, signs of senile confusion. Patients become more alert,

aged and debilitated



less confused and moody. Personal care, memory, emotional stability, social attention improve. Fatigue, apathy and irritability are reduced.

A prescription for 100 tablets of Geroniazol TT will permit your patients to enjoy the benefits of time-prolonged nicotinic acid/pentylenetetrazol therapy, at an economical price. Dosage is only one tablet every 12 hours.

Contraindications: There are no known contraindications.

Precautions: Exercise caution when treating patients with a low convulsive threshold.

Side Effects: Side effects are rarely encountered, however due to the vasodilatation effect of nicotinic acid, transitory mild nausea, flushing, tingling and pruritus are possible.

Dosage: One tablet every 12 hours.

Supplied: Prescribe bottles of 100 tablets, to take advantage of recent price reduction.

References: 1. Report by Nuclear Science & Engineering Corp., Pittsburgh, Pa., in files of Philips Roxane Laboratories. 2. Connolly, R.: W. Virginia Med. J. 56:263 (Aug.) 1960. 3. Curran, T. R., and Phelps, D. K.: Am. Pract. & Digest Treat. 11:617 (July) 1960.



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Ad Astra

Charles Arthur Belisle, M. D., Canton; Louisiana State University School of Medicine, 1955; aged 38; died December 6; member of the Ohio State Medical Association, the American Medical Association, and the Southeastern Surgical Society; fellow of the American Board of Surgery. Dr. Belisle moved to Canton from Augusta, Ga., in April of 1965. He was doing pioneer work at Aultman Hospital with the artificial kidney and was in process of establishing a clinic for patients suffering from emphysema. A veteran of World War II, he was a member of the Temple. Surviving are his widow, four sons, his mother and stepfather, and a brother.

Francis R. Canelli, M. D., Toledo; St. Louis University School of Medicine, 1945; aged 46; died December 7; member of the Ohio State Medical Association, the American Medical Association, and the American Thoracic Society. A physician and surgeon in Toledo, Dr. Canelli's practice in that area goes back to 1951.

William E. Dwyer, Sr., M. D., Cleveland; Western Reserve University School of Medicine, 1914; aged 77; died December 17; member of the Ohio State Medical Association and the American Medical Association. Dr. Dwyer was retired after devoting a lifetime to practice of obstetrics and gynecology in the Cleveland area. He was a veteran of World War I. Surviving are his widow, a daughter, and a son, Dr. William E. Dwyer, Jr., of Medina.

James Benjamin Falk, M. D., Cincinnati; Eclectic Medical College, Cincinnati, 1916; aged 75; died December 16; member of the Ohio State Medical Association, the American Medical Association, and the American Psychiatric Association. Former acting superintendent of Longview Hospital, Dr. Falk was in active military service during both World Wars, and attained the rank of colonel. He was a member of several Masonic bodies and of the Temple. Two brothers survive.

Morris Grossman, M. D., Steubenville; Western Reserve University School of Medicine, 1920; aged 72; died November 1; former member of the Ohio State Medical Association. Dr. Grossman's practice in the Steubenville area extended over 45 years. Among affiliations, he was a member of the Elks Lodge.

James B. Johnson, Jr., M. D., Newark; Medical College of Virginia, 1933; aged 58; died December 14; member of the Ohio State Medical Association, the American Medical Association,

American Fracture Association, and the International College of Surgeons. Dr. Johnson's practice in Newark dated back to 1934. During World War II he served as a military surgeon in the Pacific Theater. Dr. James H. Johnson, also of Newark, is a nephew. Other survivors include his mother and two sisters.

E. Henry Jones, Sr., M. D., Youngstown; Ohio State University College of Medicine, 1909; aged 82; died December 12; former member of the Ohio State Medical Association and the American Medical Association. In addition to his long practice in the Youngstown area and in Warren, Dr. Jones formerly served six years as Mahoning County coroner. His specialty was dermatology. Among affiliations, he was a member of the Masonic Lodge. Survivors include his widow, and his son, Dr. Edward H. Jones, Jr., also of Youngstown.

Frederick W. Kehrer, M. D., Bucyrus; Ohio Medical University, Columbus, 1904; aged 88; died December 1; former member of the Ohio State Medical Association and the American Medical Association. A native of Bucyrus and physician of long standing there, Dr. Kehrer specialized in eye, ear, nose, and throat practice. In the 1920's he took special training in the East and in Europe. Among local affiliations, he was a member of the Lutheran Church. Surviving are his widow, a daughter, and a son.

Frank H. Lever, M. D., Loveland; Medical College of Ohio, Cincinnati, 1902; aged 89; died December 4; former member of the Ohio State Medical Association. A resident of the Loveland area since childhood, Dr. Lever's practice included adjoining areas of Hamilton, Clermont, and Warren Counties. His professional career extended over some 58 years before his retirement. His community activities were numerous. He formerly served on the village council, and the local board of education; was a member of the Presbyterian Church and several Masonic bodies. Survivors include a daughter, three sons, two sisters, and two brothers.

Kay E. Liber, M. D., Canton; University of Rochester School of Medicine, 1931; aged 62; died December 24; former member of the Ohio State Medical Association and the American Medical Association; Fellow of the American College of Surgeons. An Orthopaedic surgeon of long standing in Canton, Dr. Liber was a veteran of World War II, during which he attained the rank of colonel in the Air Force. He was a member of the Presbyterian Church. Surviving are his widow, a daughter, and a sister.

Julius Ohlmann, M. D., Dayton; Medical Faculty of Albert Ludwigs University, Germany, 1911; aged 79; died December 27; member of the Ohio State Medical Association and the American Medical Association. Dr. Ohlmann was educated in Europe and his entire professional career extended over some 55 years. His practice in Dayton began in the early 1940's and consisted primarily of pediatrics. A member of the Temple, he is survived by his widow, two daughters, and a son.

Milosav Petrovich, M. D., Youngstown; Medical Faculty of the University of Belgrade, 1927; aged 67; died December 24; member of the Ohio State Medical Association. A native of Yugoslavia and former practitioner there, Dr. Petrovich served in the Yugoslavian Army during World War II. He came to this country in 1951 and moved to Youngstown six years ago. He was on the staff of Woodside Receiving Hospital. A member of the Serbian Orthodox Church, he is survived by his widow, a son, and three daughters; also two brothers and two sisters in Yugoslavia.

Charles James Ray, M. D., Gilboa; Cleveland Medical College, Homeopathic, 1895; aged 91; died December 14; former member of the Ohio State Medical Association. Dr. Ray opened his office in the Putnam County community in 1895 shortly after receiving his medical degree. He later took additional work at Harvard Medical School. A former clerk and treasurer of Gilboa, he was a member of the Methodist Church.

Charles Henry Reinacher, M. D., Cleveland; Eclectic Medical College, Cincinnati, 1929; aged 66; died December 9; member of the Ohio State Medical Association. Dr. Reinacher moved to Cleveland in 1954 after practicing for about 24 years in Covington, Ky. His specialty was proctology. Affiliations included membership in the Elks Lodge, the Catholic Church and the Knights of Columbus. His widow and a son survive.

Gerald T. Schwarz, M. D., Chesterland and Cleveland; University of Cincinnati College of Medicine, 1935; aged 59; died December 7; member of the Ohio State Medical Association, the American Medical Association, and the American Academy of Ophthalmology and Otolaryngology; diplomate of the American Board of Ophthalmology. An ophthalmologist of long standing in Cleveland, Dr. Schwarz was chief of eye service at St. Luke's Hospital. He was a trustee of the Cleveland Eye Bank, and a trustee of Heidelberg College; also a member of Immanuel Church and several Masonic bodies. Survivors are his widow, a son, and a daughter.

Frank H. Stukey, M. D., Lancaster; Ohio State University College of Medicine, 1913; aged 77; died December 14; member of the Ohio State Medical Association and the American Medical Association. Dr. Stukey was a physician of long standing in the Lancaster area, and was a veteran of World War II.

Frank H. Sweeney, M. D., Mt. Gilead; Ohio State University College of Medicine, 1932, aged 65; died December 4; member of the Ohio State Medical Association, the American Medical Association, American Academy of General Practice, and the American Society of Anesthesiologists. Dr. Sweeney was a practicing physician in the Mt. Gilead area for 33 years, and Morrow County coroner for 20 years. He was a member of the Morrow County Hospital Building Board, a member of the Presbyterian Church and several Masonic bodies. Survivors are his widow, three sons, and a sister.

Charles C. Waltenbaugh, M. D., Canton; Dunham Medical College, 1901; aged 96; died November 30. A native of Canton, Dr. Waltenbaugh practiced there over a long period of time before his retirement about four years ago. He was a member of the Methodist Church and several Masonic bodies. A daughter survives.

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References: 1. Pillsbury, D. M., Shelley, W. B., and Kligman, A. M.: A manual of cutaneous medicine, Philadelphia, Saunders, 1961, p. 79. 2. Barber, M., and Garrod, L. P.: Antibiotic and chemotherapy, Baltimore, Williams and Wilkins, 1963, p. 111.

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Deadline for Submission of Resolutions to Columbus Office of the Association Is March 16

DELEGATES to the Ohio State Medical Association and County Medical Societies planning to have resolutions submitted for consideration by the House of Delegates at the 1967 Annual Meeting should be guided by the following Constitutional requirements:

1. Resolutions, regardless of whether they have been submitted in advance and published in *The Journal*, must be introduced at the first session of the House of Delegates, Monday evening, May 15, at the Sheraton-Columbus Hotel, Columbus.
2. When the resolution is introduced, copies in triplicate should be presented.
3. To be eligible for presentation, a resolution must have been filed with the Executive Secretary of the Ohio State Medical Association, Columbus, at least 60 days prior to the first session of the House of Delegates, namely, not later than March 16. This requirement may be waived by a two-thirds majority of the House of Delegates.
4. Resolutions received will be published in *The Journal* prior to the meeting. Also copies of resolutions will be distributed to members of the House of Delegates to give them an opportunity to discuss issues with their constituents and possibly receive voting instructions from their County Medical Societies.

New Accident Insurance Program Now Protects Certain Persons Traveling on OSMA Business

The Ohio State Medical Association has contracted for travel accident insurance coverage for specified persons traveling on official business in behalf of the Association. Included under specified classes of coverage are Officers and Councilors of the Association, paid employees, OSMA delegates and alternate delegates to the American Medical Association, and members of OSMA committees as indicated on official rosters.

Three classifications for coverage are designated as follows:

Class I—Officers, Councilors, and Executive Staff employees of the Association—\$100,000;

Class II—Members of OSMA Committees as shown on official rosters, OSMA delegates and alternate delegates to the American Medical Association—\$50,000; and

Class III—Employees of the Association other than the Executive Staff—\$10,000.

The Insurance Company of North America contract provides for coverage and limitations as follows:

Twenty-four hours per day, intracity and intercity, Accidental Death and Dismemberment Insurance coverage while traveling on business for the Ohio

State Medical Association, subject to the following limits of travel:

(A) Coverage begins at the actual start of a business trip, whether it be from place of employment, home or other location.

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(D) Coverage is provided for 24 hours per day on intercity business travel and intercity business and pleasure sojourn travel.

Seminar on Newborn Scheduled April 13 in Cincinnati

The fifth annual seminar on "Clinical Problems of the Newborn" will be held at Good Samaritan Hospital, Cincinnati, on April 13. The morning session will include case presentations and informal presentations. Guest lecturers will include Dr. Ivan Diamond, Dr. William Cochrane and Dr. Joseph Dancis. There is no registration fee, but those interested in attending are requested to contact Charles V. Pfahler, M.D., Department of Pediatrics, Good Samaritan Hospital, Cincinnati, Ohio 45220.



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Woman's Auxiliary Highlights...

By MRS. S. L. MELTZER, Chairman, Publicity Committee
2442 Dorman Drive, Portsmouth 45662

I'm not making any earth-shattering announcement by stating a fact you already know — that February is the shortest month of the year. What I didn't anticipate, however, was that this column is going to be the shortest one of the year — or, for that matter, probably the "leastest" of the past three years!

It is easy to understand that this **Auxiliary Highlights**, written early in January for the February issue, is the victim of all the Christmas Holiday activities whirl which take its toll of local publicity chairmen. But I did dare to hope that some such chairman, somewhere, somehow, would have managed to slip at least a newspaper clipping my way. As it is, I have received nothing — but nothing — this past month. The only news items I can come up with are those of my own Scioto County.

From time to time, I spotlight the different state chairmanships and committees. Because my mind at this point is taken up with the problems of publicity, I reiterate something I wrote called "Publicity in a Nutshell" which is in the State Workbook:

Publicity is the interpretation of an "image" — of the purposes, aims, and activities of an auxiliary, designed to advance its interests. It covers more than what appears in the public print or on radio and television, important as all that is. The distribution of health literature and posters is an act of publicity as is the programming of special events, exhibits, health talks. Every worthwhile activity the auxiliary promotes for its community is a facet of publicity.

Whenever possible, try to give a newspaper story a legitimate news peg, so that it "makes" the news columns. The society page has its important place, of course. But we need to news-i-fy more of our projects — particularly those that benefit others — rather than place undue emphasis on our social activities. The image of the doctor's wife must be that of a woman concerned with the good of her community (as indeed most are). The local publicity chairman should be a member of the program committee (to help "spawn" ideas); create events. It requires some ingenuity, but if you keep your eyes open and senses alerted to community needs, new angles will present themselves. And never forget that ageless feature — human interest.

The State Auxiliary and the Ohio State Medical Association want to know about your various activities. To that end, PLEASE: (1) Each month, send either newspaper clippings or typewritten reports (but no photographs) to me, state publicity chairman,

for this monthly column in *The Journal*; and (2) send comparable material (preferably feature-type stories) plus pertinent photographs to the editor of *Auxiliary News* (Mrs. Paul Sauvageot). The News is published four times a year; familiarize yourself with its deadlines. Space is limited in both of the foregoing publications, so keep your copy short and to the point.

However, be sure to include the important things. And always be sure, in listing names of committee members, officers, etc., to give full names and check the spelling of those names. If it is an important activity, then I do want full details. I am convinced that your doctor-husbands are interested in what the auxiliaries are doing and many of them do take the time to read this column. So I ask again that you cooperate by sending me material. I have to be kept informed of your activities. Were I endowed with extrasensory perception. I might be able to operate on my own. But I possess no such power. I have to depend on those of you who accepted the post of publicity chairman. (If I sound somewhat desperate — well, I am!)

Scioto County

For so very many years now that I can't even remember exactly how many, the Scioto County Auxiliary has had its December meeting and Christmas party at the home of Dr. and Mrs. Clyde M. Fitch. It is always a special and festive occasion. Hilda Fitch possesses that rare quality of the perfect hostess and her home always looks like some delightful fairyland in its Christmas dress and unique touches.

The program this year boasted an international flavor in the persons of five winsome young ladies representing five foreign countries. These girls attend Portsmouth Business College. Adile Prosper, of Haiti, Maria Velez, of Mexico, and Elizabeth Villafrade, of Venezuela — all in attractive native costumes — performed the lively, colorful dances of their respective countries. Gracie Das in beige and gold sari gave interesting highlights of her native India and later demonstrated the intricacies of putting a sari together! Le Thi Tu of South Vietnam (only 11 days then in the United States) sang a touching Vietnamese Christmas Carol and told something of her native land. All five girls speak the English language amazingly well.

There was a Bake Sale (Ways and Means Com-

(continued on page 269)

(Continued from page 264)

mittee project) and a "toy shower" for the Salvation Army. Mrs. Armin Melior, AMA-ERF chairman, displayed place mats and handbags (handloomed in Tennessee) and AMA-ERF notepaper. She did a lively business. Mrs. Harlan Williams, local president, announced that the County Home would be sent the auxiliary's annual Christmas gift—a basket of fruit and candy. Those assisting Mrs. Fitch at the December party included: Mrs. Adolph Bushman, Mrs. Clyde Everett, Mrs. H. A. Green, Mrs. Philip Weems and Mrs. Richard Villarreal who was in charge of the program.

The January meeting of the Scioto group was a luncheon at Harold's Restaurant and featured a talk by Brother Leonard of the Good Shepherd Manor, a residence for mentally retarded and physically handicapped young men. (This remarkable place at Wakefield, Ohio, was the subject of a feature story in *Look Magazine* a few months ago.) Brother Leonard illustrated his talk with slides, showing the daily activities and projects undertaken by the Brothers of the Good Shepherd for their 96 mentally retarded charges of all three religious faiths. The

boys at the Manor come from all over the United States. It was undoubtedly one of the most moving presentations ever made before the local group.

At the business meeting, it was voted to become, once again, an organizational member of Project Hope. A nominating committee of five was elected to present a slate of officers for election at the February meeting: Mrs. Louis Chaboudy, chairman; Mrs. Donald Appleton, Mrs. Frank Gatti, Mrs. James F. Scott and Mrs. S. L. Meltzer. Hostesses for the January meeting included Mrs. Appleton, Mrs. Robert Counts and Mrs. Jack MacDonald.

Forward Look on TB Testing

Lederle Laboratories, Pearl River, N. Y., is distributing an attractive, well-illustrated booklet designed to stimulate participation in efforts to eradicate tuberculosis, with emphasis on tuberculin testing of all school children. Entitled "A Gift to the Future," the publication offers "a working plan to help eradicate tuberculosis."

Distribution has been made to state health officers, medical societies, and other groups. Single copies are available upon request to the company.

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Committee on School Health—Charles H. McMullen, Loudonville, Chairman; Walter Felson, Greenfield; Howard H. Hopwood, Cleveland; Dale A. Hudson, Piqua; Howard J. Ickes, Canton; Charles L. Kagay, Dayton; Thomas E. Wilson, Warren; Robert C. Markey, Bowling Green; Robert J. Murphy, Columbus; Carey B. Paul, Jr., Columbus; Carl L. Petersilge, Newark; William H. Rower, Ashland; Thomas E. Shaffer, Columbus; Aubrey L. Sparks, Warren; Homer B. Thomas, Gallipolis.

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Ohio Medical Indemnity Liaison Committee—Robert E. Tschantz, Canton, Chairman; Henry A. Crawford, Cleveland; Lawrence C. Meredith, Elyria; Mr. Hart F. Page, Executive Secretary, OSMA, Columbus.

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BUTLER—Brady Randolph, President, 128 North Front Street, Hamilton 45011; Mrs. Charles G. Greig, Executive Secretary, 110 North Third Street, Hamilton 45011. 3rd Wednesday monthly.

CLERMONT—Noco Capurro, President, 481 Craig Road, Cincinnati 45244; Phillips F. Greene, Secretary, Route 1, Box 509, New Richmond 45157. 3rd Wednesday monthly except July, August, and December.

CLINTON—H. Richard Bath, President, 290 West Main Street, Wilmington 45177; Mary R. Boyd, Secretary, Box 629, Wilmington 45177. 4th Tuesday monthly.

HAMILTON—Elmer R. Maurer, President, 3942 North Cliff Lane, Cincinnati 45220; Mr. Edward F. Willenborg, Executive Secretary, 320 Broadway, Cincinnati 45202. 3rd Tuesday monthly.

HIGHLAND—Thomas L. Jones, President, 528 South St., Greenfield 45123; Walter Felson, Secretary, 357 South St., Greenfield 45123. 3rd Tuesday bimonthly.

WARREN—George A. Rourke, President, 210 Mound Street, Lebanon 45036; Ray E. Simindinger, Secretary, 901 North Broadway Street, Lebanon 45036. 2nd Tuesday monthly.

Second District

Councilor: Theodore L. Light, Dayton 45406
2670 Salem Ave.

CHAMPAIGN—Myron J. Towle, President, 848 Scioto Street, Urbana 43078; Fred R. Denkwalter, Secretary, 848 Scioto Street, Urbana 43078. 2nd Wednesday monthly.

CLARK—H. B. Elliott, President, 25 West Harding Road, Springfield 45504; Mrs. Marion L. Wilcoxson, Executive Secretary, 616 Building, Room 131, 616 North Limestone Street, Springfield 45503. 3rd Tuesday monthly.

DARKE—William A. Browne, President, 722 Sweitzer St., Greenville 45331; Delbert D. Blickenstaff, Secretary, 552 S. West St., Versailles 45380. 3rd Tuesday monthly.

GREENE—Richard A. Falls, President, 1148 North Monroe Drive, Xenia 45385; Mrs. C. K. Elliott, Executive Secretary, 225 Pleasant Street, Xenia 45385. 2nd Thursday monthly, except July and August.

MIAMI—David Brown, President, 1060 North Market Street, Troy 45373; Jack P. Steinhilber, Secretary, 145 Sunset Drive, Piqua 45356. 1st Tuesday monthly.

MONTGOMERY—W. J. Lewis, President, 2567 Far Hills Avenue, Dayton 45419; Mr. Robert F. Freeman, Executive Secretary, 280 Fidelity Medical Building, Dayton 45402. 1st Friday monthly.

PREBLE—John D. Darrow, President, 228 N. Barron St., Eaton 45320; Willard C. Clark, Jr., Secretary, 228 N. Barron, Eaton 45320. Irregular meetings.

SHELBY—George J. Schroer, President, 322 Second Ave., Sidney 45365; Alfonsas Kisielius, Secretary, Ohio Bldg., Sidney 45365.

COUNTY SOCIETIES' OFFICERS AND MEETING DATES (Continued)

Third District

Councilor: Frederick T. Merchant, Marion 43305
1051 Harding Memorial Pky.

- ALLEN—T. L. Edwards, President, 670 West Market Street, Lima 45801; T. D. Allison, Secretary, 401 Metropolitan Bank Building, Lima 45801. 3rd Tuesday monthly (omitting June, July, and August).
- AUGLAIZE—R. S. Sobocinski, President, 7 South Blackhoof Street, Wapakoneta 45895; J. F. Bowling, Secretary, 319 West Spring, St. Marys 45885. 1st Thursday odd months, with exception of July.
- CRAWFORD—Carl Ide, President, 140 Hill Street, Bucyrus 44820; Roy Wildev, Secretary, 130 Hill Street, Bucyrus 44820. Meetings held on call.
- HANCOCK—Joseph G. Barkey, President, 120 West Foulke Street, Findlay 45840; Carson P. Cochran, Secretary, 1725 South Main Street, Findlay 45840. 3rd Tuesday monthly.
- HARDIN—John J. Roget, President, Belle Center 43310; Walter Stoll, Jr., Secretary, 900 East Franklin Street, Kenton 43326. 2nd Tuesday monthly.
- LOGAN—G. E. Munn, President, 120 East Sandusky Street, Bellefontaine 43311; J. Terebuh, Secretary, Colonial Arms Apt. 10, Bellefontaine 43311. 1st Friday monthly.
- MARION—Richard W. Mills, President, 170 Fairfax Road, Marion 43302; Alice F. Fisher, Secretary, 1040 Delaware Avenue, Marion 43302. 1st Tuesday monthly.
- MERCER—Cecil E. Pennington, President, 406 South Oak, Coldwater 45828. 3rd Thursday monthly. (Send Secretary correspondence to Richard L. Dobbins, Vice President, 119 East Fayette Street, Celina 45822.)
- SENECA—Olgierd C. Carlo, President, 53 Clay Street, Tiffin 44883; Leonard M. Cavdos, Secretary, 233 South Monroe Street, Tiffin 44883. 3rd Tuesday monthly.
- VAN WERT—Norman L. Marxen, President, Medical Arts Bldg., Fox Road, Van Wert 45891; W. L. Iler, Secretary, Medical Arts Bldg., Fox Road, Van Wert 45891. 4th Friday monthly.
- WYANDOT—Herschel A. Rhodes, President, 777 N. Sandusky Ave., Upper Sandusky 43351; J. J. Browne, Secretary, 777 N. Sandusky Ave., Upper Sandusky 43351. 2nd Tuesday monthly.

Fourth District

Councilor: Robert N. Smith, Toledo 43606
3939 Monroe St.

- DEFIANCE—George L. Boomer, President, 1075 East Second Street, Defiance 53512; Miss Lois Coffin, Executive Secretary, P. O. Box 386, Defiance 43512. 1st Saturday monthly.
- FULTON—B. H. Reed, Jr., President, Delta 43515; R. L. Davis, Secretary, Wauseon 43567. 2nd Tuesday quarterly March, June, September, December.
- HENRY—J. J. Harrison, President, 113 East Clinton Street, Napoleon 43545; Gamble S. Hall, Secretary, 834 Strong Street, Napoleon 43545. 1st Tuesday monthly.
- LUCAS—E. L. Doermann, President, 2001 Collingwood Blvd., Toledo 43620; Mr. Robert W. Elwell, Executive Secretary, 3101 Collingwood Blvd., Toledo 43610. 3rd Tuesday monthly except July and August.
- OTTAWA—V. Wm. Wagner, President, 122 East Perry, Port Clinton 43452; William Coon, Secretary, 120 East Perry, Port Clinton 43452. 2nd Thursday monthly.
- PAULDING—Roy R. Miller, President, 220 W. Perry, Paulding 45879; D. Paul Ward, Secretary, Box 416, Oakwood 45873. Meetings called.
- PUTNAM—Arthur P. Daniel, President, 144 N. Walnut, Ottawa 45875; Oliver N. Lugibihl, Secretary, Pandora 45877. 1st Tuesday monthly.
- SANDUSKY—J. L. Zimmerman, President, Memorial Hospital of Sandusky County, Fremont 43420; Mrs. Patsy J. Askins, Executive Secretary, Memorial Hospital of Sandusky County, Fremont 43420. 3rd Wednesday monthly.
- WILLIAMS—John E. Moats, President, Central Drive, Bryan 43506; Neil T. Levenson, Secretary, 907 Noble Drive, Bryan 43506. 2nd Tuesday monthly.
- WOOD—Roger A. Peatee, President, 140 S. Prospect Street, Bowling Green 43402; Douglas Hess, Secretary, 920 North Main St., Bowling Green, Ohio 43402. 3rd Thursday monthly.

Fifth District

Councilor: P. John Robecheck, Cleveland 44106
10525 Carnegie Ave.

- ASHTABULA—S. E. Gates, President, 344 State Street, Conneaut 44030; A. R. DeCato, Secretary, 3903 Lake Avenue, Ashtabula 44004. 2nd Tuesday monthly.
- CUYAHOGA—David Fishman, President, Room 404, 10515 Carnegie Avenue, Cleveland 44106; Mr. Robert A. Lang, Executive Secretary, 10525 Carnegie Avenue, Cleveland 44106.
- CEAUGA—C. K. Adrian, President, Medical Arts Building, 13221 Ravenna Road, Chardon 44024; Mrs. Martha Withrow, Executive Secretary, P. O. Box 249, Chardon 44024. 2nd Friday monthly.

LAKE—Wm. C. Downing, President, 150 Mentor Avenue, Painesville 44077; Mrs. Owen A. McLaren, Executive Secretary, 7408 Cadle Avenue, Mentor 44060. 4th Wednesday evening of January, March, May, September, and November, unless otherwise ordered by the Council.

Sixth District

Councilor: Edwin R. Westbrook, Warren 44481
438 North Park Ave.

- COLUMBIANA—Edith S. Gilmore, President, 432 W. 5th St., E. Liverpool 43920; Mrs. Cilson Koenreich, Executive Secretary, 193 Park Avenue, Salem 44460. 3rd Tuesday monthly.
- MAHONING—Harold J. Reese, President, 3720 Market Street, Youngstown 44507; Mr. Howard C. Rempes, Executive Secretary, 245 Bel-Park Building, 1005 Belmont Avenue, Youngstown 44504. 3rd Tuesday monthly.
- PORTAGE—David Palmstrom, President, 124 North Prospect Street, Ravenna 44266; William R. Brinker, Secretary, 141 East Main Street, Kent 44240. 3rd Tuesday monthly.
- STARK—M. W. Scott, President, 315 McKinley Avenue, N. W., Canton 44702; Mr. J. H. Austin, Executive Secretary, 405 4th Street, N. W., Canton 44702. 2nd Thursday monthly.
- SUMMIT—James G. Roberts, President, 655 West Market Street, Akron 44303; Mr. Sidney H. Mountcastle, Executive Secretary, 430 Grant Street, Akron 44311. 1st Tuesday monthly.
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Councilor: Sanford Press, Steubenville 43952
525 North Fourth Street

- BELMONT—D. M. Creamer, President, First National Bank Building, Bellaire 43906; Bertha M. Joseph, Secretary, Myers Building, Martins Ferry 43935. 3rd Thursday monthly, except January, May, July, and August.
- CARROLL—P. S. Whiteleather, President, Minerva 44657; T. J. Atchison, Secretary, 292 East Main Street, Carrollton 44615. 2nd Tuesday monthly, except July and August.
- COSHOCOTON—Donald E. Potts, President, 600 East Main Street, West Lafayette 43845; H. W. Lear, Secretary, 345 South 4th Street, Coshocoton 43812. 2nd Tuesday monthly.
- HARRISON—Charles Evans, President, 159 South Main Street, Cadiz 43907; G. E. Vorhies, Secretary, Scio 43988. 3rd Wednesday, March, June, September and December.
- JEFFERSON—Jacob R. Cohen, President, 341 Market Street, Steubenville 43952; Irving Dreyer, Secretary, Ohio Valley Hospital, Steubenville 43952. 4th Tuesday monthly except December, January, February.
- MONROE—Byron Gillespie, Secretary, Woodsfield 43793.
- TUSCARAWAS—Robert J. Kuba, President, 319 Grant St., Denison 44621; Thomas E. Ogden, Secretary, 138 E. Main St., Gnadenbutten. 2nd Thursday monthly.

Eighth District

Councilor: Robert C. Beardsley, Zanesville 43705
2236 Maple Ave.

- ATHENS—Hubert Whanger, President, Box 238, Athens 45701; L. A. Hamilton, Secretary, 400 East State Street, Athens 45701. 2nd Tuesday monthly, except July and August.
- FAIRFIELD—George W. LeSar, President, 216 Harmon Avenue, Lancaster 43130; Stephen R. Hodsden, Secretary, 1423 West Market Street, Baltimore 43105. 2nd Tuesday monthly.
- GUERNSEY—A. C. Smith, President, 1115 Clark Street, Cambridge 43725; Dayle O. Snyder, Secretary, 840 Wheeling Avenue, Cambridge 43725. 1st Tuesday monthly.
- LICKING—Warren Koontz, President, 99 Hudson Avenue, Newark 43055; Robert T. Parker, Secretary, 117 East Elm Street, Granville 43023. 4th Tuesday monthly.
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- MUSKINGUM—W. W. Renner, President, 812 Market Street, Zanesville 43701; Myron H. Powelson, Secretary, 2825 Maple Avenue, Zanesville 43701. 1st Tuesday monthly.
- NOBLE—Frederick M. Cox, President, Caldwell 43724; Edward G. Ditch, Secretary, Caldwell 43724. 1st Tuesday monthly.
- PERRY—Charles B. McDougal, President, 319 High St., New Lexington 43764; Michael P. Clouse, Secretary, West Main St., Somerset 43783.
- WASHINGTON—Archbold M. Jones, President, 326 Third Street, Marietta 45750; Tom D. Halliday, Secretary, 409 Second Street, Marietta 45750. 2nd Wednesday monthly.

COUNTY SOCIETIES' OFFICERS AND MEETING DATES (Continued)

Ninth District

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4th & Sycamore St.

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HOCKING—Jan S. Matthews, President, 9 East Second Street, Logan 43138; H. M. Books, Secretary, Route 3, Logan 43138. 2nd Tuesday monthly.

JACKSON—Carl J. Greever, President, 35 Vaughn Street, Jackson 45640; John W. Zimmerly, Secretary, 35 Vaughn Street, Jackson 45640. No set date for meetings.

LAWRENCE—Frank W. Crowe, President, 2110 South 9th Street, Ironton 45638; George Newton Spears, Secretary, 2213 South Ninth Street, Ironton 45638. Quarterly at called times.

MEIGS—Charles J. Mullen, President, 210½ E. Main St., Pomeroy 45769; Edmund Butrimas, Secretary, 204 E. Main St., Pomeroy 45769.

PIKE—Robert T. Leever, President, 100 East Third St., Waverly 45690; Albert M. Shrader, Secretary, East Water St., Waverly 45690. 1st Tuesday monthly.

SCIOTO—Chester H. Allen, President, 1405 Offnere Street, Portsmouth 45662; Erich Spiro, Secretary, 1735 Waller Street, Portsmouth 45662. February, April, July, October, and December (may be changes).

VINTON—Richard E. Bullock, President, 203 South Market Street, McArthur 45651.

Tenth District

Councilor: Richard L. Fulton, Columbus 43212
1211 Dublin Rd.

DELAWARE—C. S. Hambrick, President, Box 265, Delaware 43015; Tennyson Williams, Secretary, Box 265, Delaware 43015. 3rd Tuesday monthly.

FAYETTE—J. H. Persinger, President, 225 East Market Street, Washington C. H. 43160; M. H. Roszmann, Secretary, 1005 Temple Street, Washington C. H. 43160. 2nd Friday, noon, monthly.

FRANKLIN—Tom F. Lewis, President, 350 East Broad Street, Columbus 43215; Mr. W. "Bill" Webb, Executive Secretary, 17 South High Street, Suite 528, Columbus 43215. 3rd Tuesday monthly.

KNOX—Richard L. Smythe, President, 812 Coshoceton Road, Mt. Vernon 43050; Robert E. Sooy, Secretary, Box 470, Mt. Vernon 43050. 1st Wednesday evening monthly.

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MORROW—Lowell Murphy, President, 209 South Marion Street, Cardington 43315; David James Hickson, Secretary, 712 Baker Street, Mt. Gilead 43338. 1st Tuesday monthly, 6:30 P. M. dinner.

PICKAWAY—Edward L. Montgomery, President, 213 East Main Street, Circleville 43113; Carlos Alvarez, Secretary, 147 Pinckney Street, Circleville 43113. 1st Friday monthly, except July and August.

ROSS—Richard L. Counts, President, 56 East Second Street, Chillicothe 45601; Walter Kramer, Secretary, 39 West Main Street, Chillicothe 45601. 1st Thursday monthly.

UNION—Malcolm MacIvor, President, 110 N. Court St., Marysville 43040; May B. Zaugg, Secretary, 225 Stockdale Drive, Marysville 43040. 1st Tuesday, February, April, October, December.

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1749 Cleveland Road

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ERIE—W. P. Skirball, President, 1218 Cleveland Road, Sandusky 44870; Mrs. David Wolfert, Executive Secretary, 1428 Hollywood Road, Sandusky 44870. 2nd Tuesday monthly.

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HURON—Richard L. Jackson, President, 15 East Emerald Street, Willard 44890; John Rosso, Secretary, 218 Myrtle Avenue, Willard 44890; 2nd Wednesday of February, April, June, August, October, and December.

LORAIN—Robert S. VanDevort, President, 230 Hamilton Avenue, Elyria 44035; Mrs. Gladys Davidson, Executive Secretary, 428 West Avenue, Elyria 44035. 2nd Tuesday monthly, except June, July, and August.

MEDINA—B. A. Kassel, President, 750 East Washington Street, Medina 44256; Mr. A. Dana Whipple, Executive Secretary, 320 East Liberty Street, Medina 44256. 3rd Thursday monthly.

RICHLAND—Wendell M. Bell, President, 480 Glessner Avenue, Mansfield 44903; Mrs. M. K. Leggett, Executive Secretary, Mansfield General Hospital, Mansfield 44903. 3rd Thursday monthly.

WAYNE—Howard MacMillan, President, 1740 Cleveland Road, Wooster 44691; R. J. Watkins, Secretary, 1736 Beall Avenue, Wooster 44691. 2nd Wednesday monthly, January, February, April, September, November and December.

State Medical Board of Ohio

Issues Licenses to 88

The State Medical Board of Ohio recently announced the names of 88 persons who have been issued licenses to practice medicine and surgery in this state, through endorsement of their licenses to practice in states having reciprocity with Ohio, or through certification by the National Board of Medical Examiners.

Dr. Darell Smith spoke at luncheon meeting of the Cambridge Kiwanis Club, using as his topic, "Moral Dilemmas in Modern Medicine."



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Heart-Cancer-Stroke Grant Area Would Include S-W Ohio

A grant of \$346,760 has been awarded by the U. S. Public Health Service to support the first 12 months of a two-year planning effort by the Ohio Valley Regional Medical Program, to develop one of a nationwide network of regional medical programs designed to combat heart disease, cancer, stroke, and related diseases. The program will operate under provisions of Public Law 88-239, or the Heart Disease, Cancer, and Stroke Amendments of 1965.

The local region will serve southwestern Ohio, southern Indiana, the western tip of West Virginia, and most of Kentucky.

Major metropolitan areas which will be within the region include Cincinnati and Dayton, Ohio; Evansville, Ind.; Huntington, W. Va.; and Lexington and Louisville, Ky.

The application for grant funds to develop the program has been jointly sponsored by the Universities of Cincinnati, Kentucky, and Louisville.

Announcement of the grant was made jointly by Dr. Clifford G. Grulee Jr., dean of the University of Cincinnati College of Medicine; Dr. Donn L. Smith, dean, University of Louisville School of Medicine, and Dr. William R. Willard, vice-president for the University of Kentucky Medical Center.

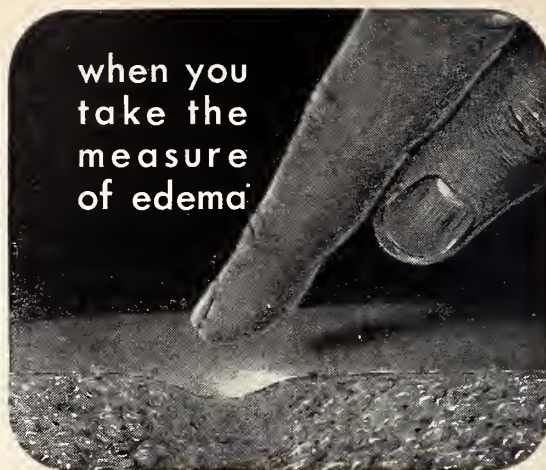
Aim of the program is to improve and enhance the region's medical capability through voluntary cooperative arrangements which relate the region's existing health resources in programs of research, education and training, and patient care demonstration.

The program will provide a continuing basis for more formal and effective relations between the area's three university medical centers and the community hospitals and practicing physicians. Such cooperative arrangements are intended to aid practitioners and institutions of the region with the most rapid possible translation of research accomplishments into patient care.

Dr. William H. McBeath, Lexington, Ky., recently named director of the program, stated that the award of the grant will permit substantive planning activities to begin immediately with the active involvement of practicing physicians, community hospitals, voluntary health agencies, public health departments, and others within the region.

Development of the Ohio Valley Regional Medical Program will be guided by a regional advisory council, representative of the citizenry and health resources of the area.

The American College of Physicians (ACP) will sponsor a five-day postgraduate course March 20-24 on "Fundamental Concepts of Gastroenterology" in Ann Arbor, Mich.



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AQUATAG (Benzthiazide) is a potent, orally active, nonmercurial, diuretic agent. It is effective orally in producing diuresis in edema states, where it is therapeutically comparable to mercurials given parenterally. AQUATAG (Benzthiazide) is mildly antihypertensive in its own right and enhances the action of other antihypertensive drugs when used in combination.

DIURETIC ACTION: Clinically, the oral administration of AQUATAG (benzthiazide) results in diuretic activity within two hours with maximal natriuretic, chloruretic, and diuretic effects occurring during the fourth, fifth and sixth hours. Maintenance of response continues for approximately 12 to 18 hours. Acidosis is an unlikely complication since therapeutic doses of AQUATAG (benzthiazide) do not appreciably increase bicarbonate excretion. Edematous patients receiving 50 mg. of AQUATAG (benzthiazide) daily for five days developed a maximal increase in the rate of sodium excretion on the first day, and maintained this high rate until depletion of excessive body stores of sodium.

In congestive heart-failure patients, AQUATAG (benzthiazide) produced the same weight loss during a 48-hour treatment period as did a maximally effective dose of hydrochlorothiazide.

DOSAGE: Diuresis, initially 50 to 200 mg.; maintenance 25 to 150 mg., daily. Hypertension 50 to 100 mg. initially, adjusted to 50 mg. t.i.d. or downward to minimal effective dosage level.

WARNINGS: Use with caution in the presence of renal disease as azotemia may be precipitated or increased. In patients with advanced hepatic disease, electrolyte imbalance may result in hepatic coma. Dosage of coadministered antihypertensive agents should be reduced by at least 50%. In cases of suspected electrolyte imbalance, serum electrolyte determinations should be performed and imbalance, if any, corrected. Stenosis or ulcer of small intestine have been reported with coated potassium tablets, and surgery has been required and deaths have occurred. Based on surveys of both United States and foreign physicians, incidence of these lesions is low and a causal relationship in man has not been definitely established. Until further experience has been obtained, the use of the drug in pregnant patients should be weighed against possible hazards to the fetus.

CONTRAINDICATIONS: AQUATAG (benzthiazide) is contraindicated in progressive renal disease or dysfunction including increasing oliguria and azotemia. Continued administration of this drug is contraindicated in patients who show no response to its diuretic or antihypertensive properties. Severe hepatic disease is a relative contraindication. (See "Warnings" above.)

PRECAUTIONS AND SIDE EFFECTS: Electrolyte imbalance with hypokalemia (digitalis toxicity may be precipitated), hypochloremic alkalosis and hyponatremia may occur. Patients with cirrhosis should be observed for impending hepatic coma and hypokalemia. Other reactions may include blood dyscrasias, hyperuricemia and gout, nausea, jaundice, anorexia, vomiting, diarrhea, dizziness, paresthesia, photosensitivity and headache. Hepatic fetor, tremor, confusion and drowsiness are signs of impending pre coma and coma in patients with cirrhosis. Insulin requirements may be altered in diabetes. AQUATAG (benzthiazide) should be used with caution post-operatively as hypokalemia is not uncommon. Potassium supplementation may be advisable pre- and post-operatively. There have been occasional reports of thrombocytopenia, leukopenia, agranulocytosis, aplastic anemia and precipitation of acute pancreatitis or jaundice.

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Comments on Current Economic, Social And Professional Matters

GOVERNMENT CONTROL OF MEDICINE; OR WHY EUROPEAN DOCTORS LEAVE HOME

In the past eight years nearly 125,000 of Europe's best educated young people have in one way or another sought admittance into the United States. With this information as a background, the American Medical Association offered some pertinent comments, among which are the following:

Far more concerned with the outcome of the brain drain, however, is Great Britain. The emigration of its young physicians has threatened Britain's National Health Service (NHS) with collapse.

According to their own surveys, about one-third of Britain's medical graduates are leaving the country each year. What's more, the number of medical students going into training has been falling steadily.

An eminent barrister, R. H. Davison, outlining the British health service dilemma, reported in the *British Medical Journal*: "Not only has the NHS provided outrageous terms and conditions of service, it has completely failed to inspire respect among the younger members of the profession who see through its Fabian humbug."

He noted that even the supply of doctors being imported from Pakistan and India to help fill the vacuum of British doctors was dwindling, and criticized the government suggestion "that the advent of the Common Market will permit us to import Italian doctors to run our Health Service."

"Clearly," Davison wrote, "fourteen years of socialism have made us completely shameless, for no one can believe these policies to be in the national interest."

That was five years ago. Since then the tempo of emigration from Britain has accelerated despite government efforts.

Why? The consensus of those British physicians arriving in this country seems to be that they have no wish to be "hand maidens of the government."

As one young resident said: "We're not exactly forced into servitude by the government, but we're not exactly free to practice our profession either."

In our opinion, the paradox of all this is obvious: Europeans are eager to taste of the American way of medical practice, while Americans can't wait to snatch up the scraps of government controlled medicine they leave behind.

PERCENTAGEWISE OR OTHERWISE, ACCIDENT DEATH RATE RISING

"Of course our accident death rate is rising; the population is increasing and people are driving more than ever." Neither of those arguments are valid, according to the following statistics put together by the Metropolitan Life Insurance Company:

Accidents in the United States claimed 5,000 more lives in 1966 than in 1965, according to Metropolitan Life. Last year's death toll was about 112,000, or some 20,000 more than five years ago.

The 1966 accidental death rate of 57 per 100,000 population was four per cent over the rate for the previous year and 13 per cent higher than in 1961.

The major reason for the upswing was the continuing rise in motor vehicle fatalities. The 53,000 persons who perished in motor vehicle accidents in 1966 outnumbered by 4,000 their counterparts of the year before. At 27 per 100,000, the 1966 death rate from motor vehicle accidents was by far the highest in a quarter of a century. Metropolitan's statisticians also estimated from preliminary data that the rate of accidental deaths per 100 million miles traveled was slightly above the 5.6 recorded in 1965.

Accidents in and about the home also accounted for a substantial portion of the rise. There were 29,000 such deaths in 1966, about 1,000 more than in 1965.

However, the death toll from catastrophes — accidents claiming five or more lives — was smaller in 1966 than a year ago. Although motor vehicle and water transportation catastrophes caused more deaths, this was offset by a smaller loss of life in tornadoes, civil and military aviation, hurricanes, floods, fires, and explosions.

HELP FOR THOSE WHO WOULD HELP THE HEALTH CAREER RECRUIT

When parents and their teenage offspring begin pondering the merits of a career in medicine or one of its allied fields, it is only natural that they should turn to their physicians for advice and counsel.

The physician in turn can do both himself and those making career inquiries a favor by looking to the American Medical Association for a helping hand to augment any personal advice or suggestions. As a service to members, the Association offers a variety of complimentary literature and other aids describ-

ing guidelines for students seeking to prepare for rewarding careers in medicine or its allied fields.

The AMA currently handles up to 35,000 individual careers inquiries annually from physicians, individuals in allied professions and occupations, members of women's auxiliaries, counselors, libraries, students, and parents. That is an average of 130 inquiries per working day. But during peak periods — October - November and March - April — when many schools and communities conduct special careers programs, as many as 300 a day are received.

Since 1960 the AMA has expended more than \$750,000 in developing and carrying out its comprehensive careers programming effort.

The AMA's latest contribution to health careers literature is the colorful, 144-page paperback, *Horizons Unlimited*, introduced last April. Designed primarily for upper high school and beginning college students and those concerned with counseling, the two-part publication covers medicine in depth and highlights career opportunities existing in eight major allied fields.

Officers of County Medical Societies interested in a medical careers program, or individual physicians, are invited to write for a list of materials available to: Program Services Department, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

Ohio Physicians Participate On ACP New York Program

Five Ohio physicians will be on the faculty when the American College of Physicians presents a program on "Recent Advances in Cardiovascular Disease," March 6-10 in New York City. They are the following:

Dr. Donald B. Effler, chief of the Department of Thoracic and Cardiovascular Surgery, Cleveland Clinic Foundation.

Dr. Noble O. Fowler, professor of medicine and director of the Cardiac Research Laboratory, University of Cincinnati College of Medicine.

Dr. Ray W. Gifford, Jr., Department of Hypertension and Renal Disease, Cleveland Clinic Foundation.

Dr. William L. Proudfit, head of the Section on Clinical Cardiology, Cleveland Clinic Foundation.

Dr. Earl K. Shirey, Department of Cardiovascular Disease and Cardiac Laboratory, Cleveland Clinic Foundation.

The ACP will present one of its postgraduate courses in Ohio during the season. The course on "Internal Medicine; Current Physiological Concepts in Diagnosis and Treatment," will be held in cooperation with the University of Cincinnati College of Medicine, June 12-16, with Dr. Richard W. Vilter, as director.

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Therapeutic Effects: Tandearil is a nonhormonal compound which may rapidly resolve inflammation and help restore normal joint function. Its action does not affect pituitary-adrenal function or impair immune responses. Its value in osteoarthritis is especially noteworthy because this disorder responds inconsistently to steroids and is often resistant to salicylates. Further, indomethacin is limited only to osteoarthritis of the hip, whereas oxyphenbutazone is effective in all forms of the disease.

Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently.

Warning: If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with great caution in the first trimester of pregnancy.

Precautions: Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should be closely supervised and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools or other evidence of intestinal hemorrhage. Make regular blood counts. Discontinue the drug and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The most common are nausea, edema and drug rash. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. Infrequently, agranulocytosis, or a generalized allergic reaction may occur and require withdrawal of medication. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

Dosage in Osteoarthritis: The initial daily dosage in adults is 300-600 mg. in divided daily doses. When improvement occurs, dosage should be decreased to the minimum effective level; this should not exceed 400 mg. daily, and is often achieved with only 100-200 mg. daily.

For complete details, please refer to full prescribing information. 6562-VI(B)R

Availability: Tablets of 100 mg.



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Insurance Group Plans Now Protect 67 Million

Group health insurance programs provided by insurance companies protected more Americans in 1965 than ever before, the Health Insurance Institute said.

According to the Institute, all five prime coverages—hospital, surgical, regular medical, major medical, and disability income—registered sizable increases in persons protected.

Moreover, benefits under insurance company group programs totaled a record \$4 billion in 1965, over \$400 million more than was similarly distributed in 1964.

Here are the 1965 coverage figures by type of coverage:

Group hospital expense coverage—67.1 million persons. In 1964, 64.5 million.

Group surgical expense coverage—67.6 million persons. In 1964, 64.9 million.

Group regular medical expense coverage—50.6 million persons. In 1964, 47.4 million.

Group major medical expense coverage—47.3 million persons. In 1964, 42.6 million.

Group disability income coverage—26.5 million persons. In 1964, 24.4 million.

Growth of group health insurance by insurance companies is reflected both in the numbers of persons protected over the years and benefits paid. For ex-

ample, in 1945, some 7.8 million persons had group hospital expense coverage under an insurance company plan. In 1955, the figure was 39 million. And 10 years later, 67.1 million.

Benefits meanwhile, under insurance company group programs, amounted to \$139 million in 1945, nearly \$1.3 billion in 1955, and \$4 billion in 1965.

The Institute said that at the beginning of last year, 667 insurance companies were writing group health insurance in the United States, 193 more than five years earlier, and 363 more than in 1955.

Pamphlet Describes the Services And Activities of the AMA

What is the American Medical Association? How does it operate? What are some of its major areas of activities and accomplishments?

A 32-page pamphlet published by the Association readily answers such questions. The publication is equally suitable for distribution to medical society members, prospective members, and the general public.

Requests for single copies or quantity orders should be directed to the Program Services Department, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610. There's no charge.

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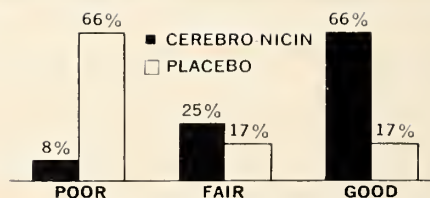
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*A Double-Blind Study of Cerebro-Nicin, Therapy for the Geriatric Patient, R. Goldberg, Jnl. of the Amer. Ger. Soc., June, 1964.

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CONTRAINDICATIONS: There are no known contraindications to Pentamethylene Tetrazole although caution should be exercised when treating patients with a low convulsive threshold. Most persons experience a flushing or tingling sensation after taking a higher potency niacin-containing compound. As a secondary reaction some will complain of nausea and other sensations of discomfort. This reaction is transient and is rarely a cause of discontinuance of the drug if the patient is forewarned to expect the reaction. Federal law prohibits dispensing without a prescription.

AMA Film Lending Service Up New Catalog Available

A total of 14,064 medical and health films were lent to physicians, hospitals, medical schools, or other professional groups by the American Medical Association Film Library during 1966.

The number of bookings was the greatest ever recorded at the library, increasing 21 per cent over 1965.

A major portion of the increase was due to the addition of films formerly distributed by the Association of American Medical Colleges and the American College of Obstetricians and Gynecologists. The largest single users of films from the AMA library were civilian hospitals and schools of nursing. Every U. S. medical school except two and 10 foreign medical schools used the services of the Film Library during the year. Paramedical schools were increasingly heavy users accounting for over 10 per cent of the total bookings.

The library now consists of 2,269 copies of 489 films. The total includes 124 health films which can be used by physicians who are invited to address lay groups. A current list of these films is now available.

A new and revised edition of "Medical and Surgical Motion Pictures," the American Medical Association's catalog of selected medical and health films, is available. More than 1,000 new film titles have

been added in the new edition of the catalog, bringing the total film listings to more than 4,000. Copies of the catalog are available without charge from the Medical Motion Picture Section, Department of Postgraduate Programs, American Medical Association, 535 N. Dearborn St., Chicago, Illinois 60610.

Cincinnati U Offers Course Series In Community Health Work

Continuing education for professional personnel in community mental health work will be offered this spring by the University of Cincinnati Medical Center Department of Psychiatry in conjunction with the Ohio Division of Mental Hygiene.

For this work the Ohio Board of Regents has allocated to UC \$78,000 in funds from the U. S. Department of Health, Education, and Welfare. Dr. W. Donald Ross, UC professor of psychiatry, is first chairman of the program's policy committee.

UC's Medical Center will offer intensive courses of four weeks duration four times each year. Trainees will be selected mainly from agencies of the Ohio Division of Mental Hygiene.

Faculty members will come from UC's Departments of Psychiatry and Psychology, the Ohio Division of Mental Hygiene; with the addition of guest lecturers.



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1. Bradley, J. E., *et al.*: *J. Pediat.* 38:41 (Jan.) 1951.
2. Bradley, J. E.: *Mod. Med.* 20:71 (Oct. 15) 1952.
3. Crunden, A. B., Jr., and Davis, W. A.: *Am. J. Obst. & Gynec.* 65:311 (Feb.) 1953.



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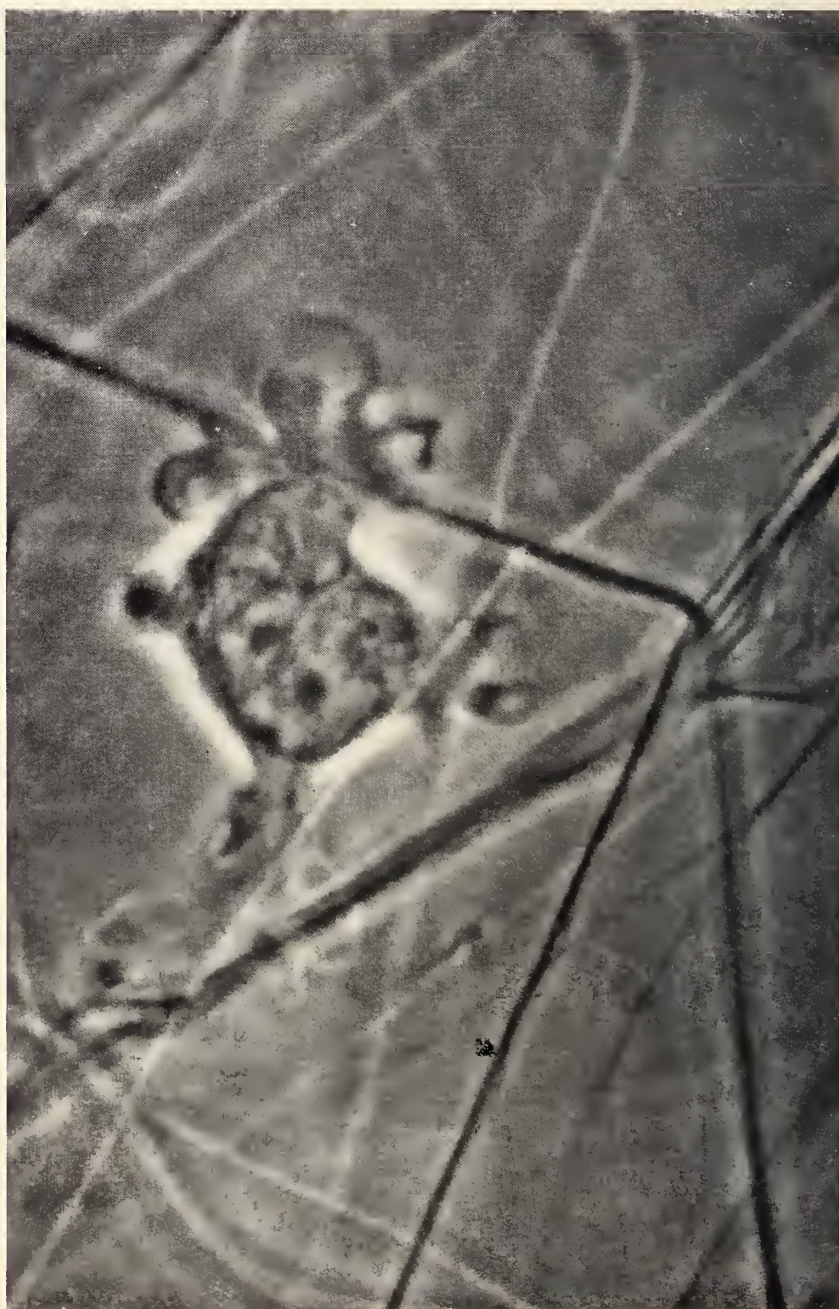
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INFLAMMATION: A cellular fight for life

A SYNTEX REPORT based on recently developed hypotheses about topical corticosteroids, including the cellular theories of inflammation by Thomas F. Dougherty, Ph.D., University of Utah.

You are looking at a fibroblast fighting for life. This cell—one of the most common found in connective tissue—has literally been poisoned by cytotoxins released from other cells that have ruptured. Soon, if the abnormal activity of this fibroblast does not cease, it, too, will rupture and die—one more casualty in the inflammatory wave of destruction precipitated by injury.

Until a short time ago no one had ever witnessed such a scene at the cellular level. Now, through advanced cinemicrographic techniques, it is possible to view and photograph the inflammatory process as produced experimentally in living animal tissue. This method permits new insight into the mechanism of inflammation and the role of corticosteroids in therapeutic management. Equally important, these techniques shed new light on factors that may make one corticosteroid more effective than another—factors that can be correlated with other chemical, biologic, and clinical parameters.



Worldwide clinical experience confirms the predictable therapeutic potential of Synalar

It is particularly gratifying that the promise of the advanced chemical design and high order of bioassay activity of Synalar (fluocinolone acetonide) has been confirmed by widespread therapeutic application. Indeed, the impressive clinical response rate of Synalar has been documented in no fewer than 232 papers from 22 countries.

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For initiation of therapy: Cream 0.025%, 5 and 15 Gm. tubes, 425 Gm. jars; *for emollient effect:* Ointment 0.025%, 15 Gm. tubes; *for maintenance therapy:* Cream 0.01%, 15 and 45 Gm. tubes, 120 Gm. jars; *for intertriginous or hairy sites:* Solution 0.01%, 20 cc. and 60 cc. plastic squeeze bottles; *for infected inflammatory dermatoses:* Neo-Synalar® Cream (0.025% fluocinolone acetonide, neomycin sulfate, equivalent to 0.35% neomycin base), 5 and 15 Gm. tubes.

CONTRAINDICATIONS: Tuberculous, fungal, and most viral lesions of the skin, (including herpes simplex, vaccinia, and varicella). Not for ophthalmic use. Contraindicated in individuals with a history of hypersensitivity to any of the components. **PRECAUTIONS:** Synalar preparations are virtually nonsensitizing and nonirritating. However, the solution may produce burning or stinging when applied to denuded or fissured areas. In some patients with dry lesions, the solution may increase dryness, scaling or itching. While topical steroids have not been reported to have an adverse effect on pregnancy, the safety of their use on pregnant females has not absolutely been established. Therefore, they should not be used extensively on pregnant patients, in large amounts, or for pro-

Representative Clinical Results with Synalar*

Efficacy Documented in over 4,000 Patients

Condition	Number of Publications	Number of Patients	Significant Improvement†
Contact Dermatitis	27	750	713
Eczematous Dermatitis	21	472	409
Seborrheic Dermatitis	18	442	426
Atopic Dermatitis	24	460	426
Psoriasis	36	1,699	1,510
Neurodermatitis	18	351	324
Total	144	4,174	3,808

*Complete bibliography on request.

†Expressed by the authors as excellent, very good, good, complete remission of inflammation, etc.

longed periods of time. Prolonged use of any antibiotic may result in overgrowth of nonsusceptible organisms; if this occurs, appropriate therapy should be instituted. When severe local infection or systemic infection exists, the use of systemic antibiotics should be considered, based on susceptibility testing. **SIDE EFFECTS:** Side effects are not ordinarily encountered with topically applied corticosteroids. As with all drugs, however, a few patients may react unfavorably to Synalar under certain conditions. The neomycin in Neo-Synalar Cream rarely produces allergic reactions.

REFERENCES: 1. Lerner, L. J., Bianchi, A., Turkheimer, A. R., Singer, F. H., and Borman, A.: Anti-inflammatory steroids: potency, duration and modification of activities. *Ann NY Acad Sci* 116:1071 (Aug. 27) 1964. 2. Idem: Comparison of anti-granuloma, thymolytic and glucocorticoid activities of anti-inflammatory steroids. *Proc Soc Exp Biol Med* 116:385 (June) 1964. 3. Ringler, A.: Activities of adrenocorticosteroids in experimental animals and man, in Dorfman, R. I.: *Methods of hormone research*, New York, Academic Press, 1964. vol. III. pp. 234-280. 4. Gubersky, V. R.: To be published.

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Ohio Study Throws Light on How Patients Take Medicines

Physicians have long known that some patients don't follow orders for taking medicine, or refuse to take it at all.

A report in the January 16 issue of *The Journal of the American Medical Association*, based on a study made in Cleveland throws some light on how frequently doctor's orders may not be followed.

Among a group of Cleveland tuberculosis patients, 15 (30 per cent) of 50 patients were uncooperative about taking one drug, and 14 (42 per cent) of 33 failed to follow doctors' orders for taking another.

"In this era of potent and dangerous medications, patient reliability in taking drugs becomes a primary consideration," the article said. "Most physicians are aware that some patients fail to take prescribed medicines, but few realize the extent of the problem."

The study started with clinic and pharmacy records at the University Hospital of Cleveland, which indicated that 50 persons in the outpatient department were supposed to be taking the drugs isoniazid and/or aminosalicylic acid.

It became apparent large numbers of patients weren't following directions when urine tests failed to reveal any trace of the drugs.

There were 20 men and 30 women patients, ranging in age from 17 to 78, with an average and median age of 45. Forty-eight were known to have tuberculosis.

An earlier study, for instance, indicated that 83 per cent of families claimed to have given a full 10-day course of penicillin to their children when evidence indicated that 82 per cent had stopped the medicine by the ninth day.

Some patients also tend to deny taking medicines when they have. One study found that 29 of 38 patients who had taken meprobamate, barbiturates, or phenothiazines denied taking these drugs.

S. S. Hope Team Now Serving In The Colombia Area

A team consisting of 104 doctors, nurses, and technologists sailed from Philadelphia early in February aboard the *S. S. Hope* to begin a 10-month's medical teaching-treatment mission in Colombia.

The *Hope* team, representing 25 states and two foreign countries, is making its base in Cartagena where it is working with their Colombian medical colleagues aboard the ship and in hospital facilities ashore.

The voyage to Colombia marks the third visit of the *S. S. Hope* to South America. In 1962-63, the medical programs were conducted in Peru and in 1964, Ecuador. Other nations visited since its maiden voyage in 1960 include Indonesia, South Vietnam, Guinea, and Nicaragua. *Hope* shore-based centers remain in Vietnam, Peru, Ecuador, and Nicaragua.

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Physicians' Placement Service One of the AMA's Programs

Following are excerpts from an article describing the background and operation of one of the American Medical Association's programs for its members and for the public—the Physicians' Placement Service.

When the rapidly approaching end of World War II loomed on the horizon in 1944, physicians on the home front foresaw the imperative need to establish an organized program to help their military counterparts return to civilian practice.

So, in December of that year, the House of Delegates of the American Medical Association established a Bureau of Information to "assist returning medical officers in their educational, licensure, and placement problems."

Since the Bureau had been envisioned only as a temporary project, it was abolished in November, 1947, because it was logically assumed that its purpose—relocation of medical officers—had by then been largely accomplished. Its work was transferred to the Council on Medical Service until the "tapering off" process of service requests was completed.

But the requests never stopped. The war, directly or indirectly, had spurred profound changes. The wartime interruption of their medical practices gave medical officers an opportunity to think out their futures. It opened their eyes to new challenges and opportunities. Many physicians chose to capitalize on the chance to continue their medical education and enter specialty training.

Population patterns were changing. Some physicians took this as their cue to search for more attractive locations in which to practice. Others decided they wanted to seek out opportunities in entirely different geographic locations which held personal appeal for them. The unprecedented, uninterrupted period of post-war prosperity has served to multiply this mobility.

Consequently, the service originally performed as a temporary expedient by the Bureau of Information not only never stopped, but has mushroomed into a major, continuing AMA service to physicians, those seeking physicians and to the nation at large.

Established as the successor unit to the Bureau in 1948, the AMA Physicians' Placement Service has processed applications from 26,140 physicians seeking to be "placed" and registered 31,760 openings during its 18 years of existence. The service is provided without any charge or obligation.

Indicative of the increasingly significant role being played by PPS on a national level is the fact that it had 3,196 openings registered and 2,750 physician registrants in 1966. Back in 1948 it had a mere 200 openings and three times that number of registrants.

The AMA Physicians' Placement Service works closely with all state medical societies, about two-

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Each tablet contains:

Potassium Iodide 195 mg.
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MUDRANE GG—Formula, dosage and package identical to Mudrane—*except*—100 mg. glyceryl guaiacolate replaces the potassium iodide. The value of Mudrane cannot be enjoyed by a small group in which K.I. is contraindicated. Mudrane GG is prepared for this group.

MUDRANE GG ELIXIR—Four 5 cc teaspoonfuls is equivalent to one Mudrane GG tablet. Dosage adjusted to age and weight of child. Mudrane GG Elixir is for pediatric patients and those who think they cannot swallow tablets. Dispensed in pint and half gallon bottles.

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thirds of whom have ongoing placement programs, and with those county medical societies who have such programs. It exchanges information with them on registrant applications and practice opportunities of mutual interest. (The Ohio State Medical Association operates such a service.)

But its dominant role and chief reason for existence lie in bringing together physicians and opportunities which are in different states or geographic areas.

Strictly speaking, the AMA Physicians' Placement Service is not a "placement" service at all. Its job is to supply information to applicants and those listing openings in an attempt to match their respective needs—to help find the "right" physician for the "right" location or position. Once brought together, two interested parties then seek to work out mutually satisfactory arrangements.

The Children's Hospital of Philadelphia and the Department of Pediatrics of the University of Pennsylvania School of Medicine, offer a five-day refresher course May 1-5. Details may be obtained from the hospital at 1740 Bainbridge Street, Philadelphia, Pa. 19146.

The Psychoanalytic Forum is a new quarterly being published at 10921 Wilshire Boulevard, Los Angeles, California 90024. Subscription rate is \$25 per year.


IRS Pleads for Accuracy on Federal Tax Returns

Missing or inaccurate social security numbers on Federal Tax returns held up more refunds for Ohio taxpayers last year than did anything else.

Paul A. Schuster, district director for Southern Ohio, said that unless a tax return is properly identified by number it cannot be processed. In some cases the number can be obtained from Social Security records while in others the taxpayer has to be contacted. "Either way, any refund that may be due the taxpayer is held up until the accurate number is obtained," he said.

Mr. Schuster said when a joint return is filed, the social security numbers of both husband and wife are required if they each have income. "If the husband is the major breadwinner of the family but the wife has a part-time job, owns stock in her own name or has her own savings account, then the wife's number must also be entered on the return. The wife's number should be listed on joint returns even though her income is less than \$600."

A number is sometimes entered inaccurately on a return when the taxpayer accidentally transposes two numbers. To make sure an accurate number is entered on the return, Schuster advised taxpayers to copy their number directly from their social security cards.



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ANDROID	GOOD TO EXCELLENT 75%
PLACEBO	20%

percent 0 10 20 30 40 50 60 70 80 90 100

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- Excellent to good results, 75% with Android, 20% with Placebo.
- Cites synergism between androgen and thyroid.
- No side effects in patients treated.
- Alleviation of fatigue noted.
- Case histories on 4 patients.
- Although psychotherapy still needed, role of chemotherapy cannot be disputed.

*"Sexual impotence treatment with methyl testosterone - thyroid (ANDROID) a double blind study" - Montesano, Evangelista: Clinical Medicine, April 1966.

CONTRAINDICATIONS — Methyl testosterone is not to be used in malignancy of reproductive organs in male, coronary heart disease, hyperthyroidism. Thyroid is not to be used in heart disease, hypertension unless the metabolic rate is low.

CAUTION: Federal law prohibits dispensing without prescription.

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Each yellow tablet contains:

Methyl Testosterone.....	2.5 mg.
Thyroid Ext. (1/6 gr.).....	10 mg.
Glutamic Acid.....	50 mg.
Thiamine HCL.....	10 mg.

Dose: 1 tablet 3 times daily.

Available:

Bottles of 100, 500, 1,000.

ANDROID-HP

Each red tablet contains:

Methyl Testosterone.....	5.0 mg.
Thyroid Ext. (1/2 gr.).....	30 mg.
Glutamic Acid.....	50 mg.
Thiamine HCL.....	10 mg.

Dose: 1 tablet 3 times daily.

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Thiamine HCL.....	10 mg.

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Each white tablet contains:

Methyl Testosterone.....	2.5 mg.
Thyroid Ext. (1/4 gr.).....	15 mg.
Thiamine HCL.....	25 mg.
Ascorbic Acid (Vit. C).....	250 mg.
Glutamic Acid.....	100 mg.
Pyridoxine HCL.....	5 mg.
Niacinamide.....	75 mg.
Calcium Pantothenate.....	10 mg.
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**Crista
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Lamina cribrosa ossis ethmoidalis

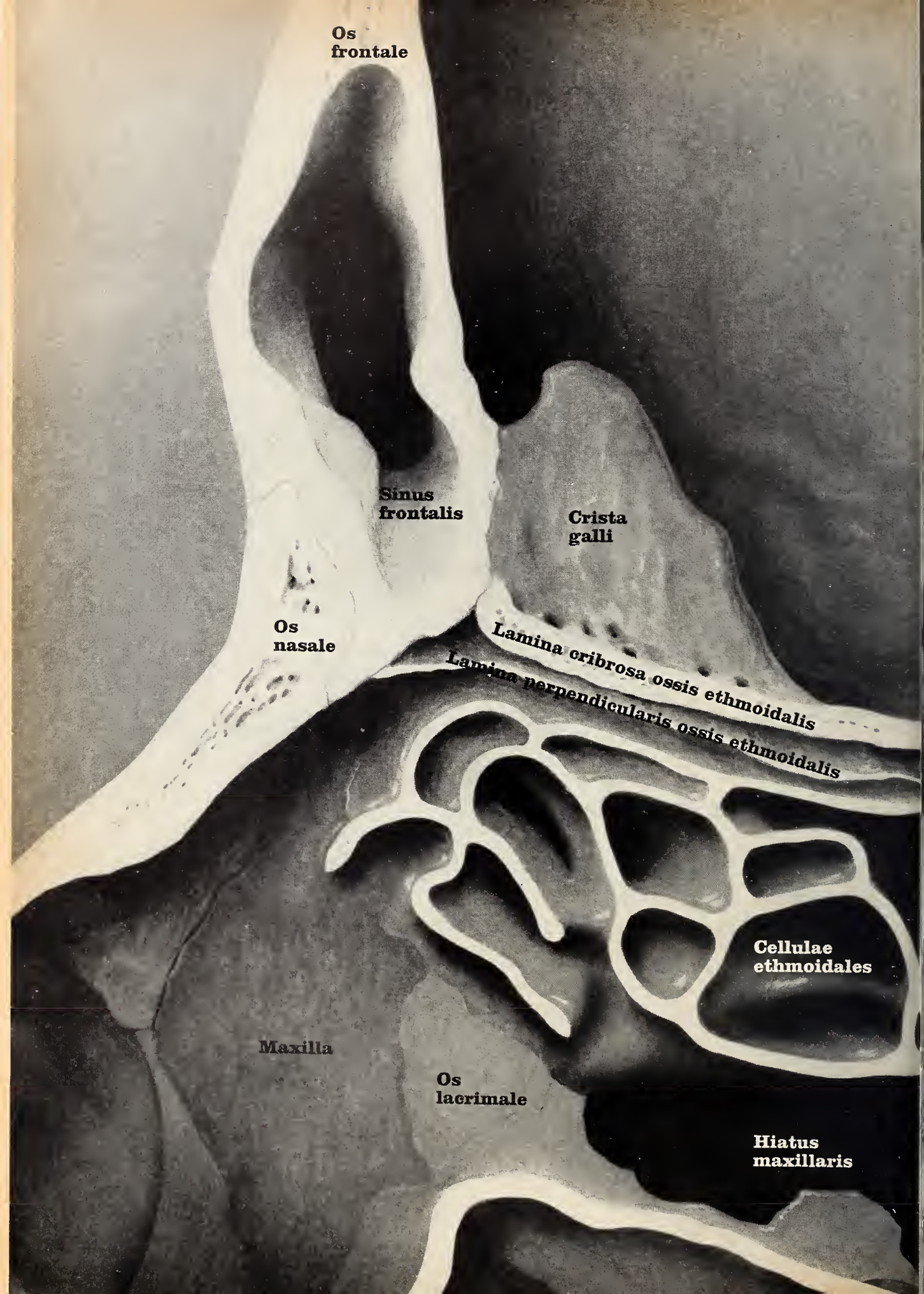
Lamina perpendicularis ossis ethmoidalis

**Cellulae
ethmoidales**

Maxilla

**Os
lacrimale**

**Hiatus
maxillaris**



TABLETS

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(meprobamate and
ethoheptazine citrate with
aspirin)



Precautions: Keep out of reach of children. Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use of meprobamate may result in dependence or habituation in susceptible persons—as ex-addicts, alcoholics, severe psychoneurotics. Withdraw gradually after prolonged high dosage to avoid possibly severe withdrawal reactions including epileptiform seizures. Warn patients of possible reduced alcohol tolerance. If drowsiness, ataxia or visual disturbances occur, reduce dose. If symptoms persist, caution patients against operating machinery or driving. Give cautiously to patients with suicidal tendencies. Treat attempted suicide with immediate gastric lavage and appropriate supportive therapy.

Side Effects: Ethoheptazine and aspirin may occasionally cause nausea, vomiting, epigastric distress, and rarely dizziness and CNS depression. Overdosage may result in salicylate intoxication. Meprobamate rarely causes allergic or idiosyncratic reactions. These reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Mild reactions are characterized by urticarial or erythematous maculopapular rash. Acute non-thrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever have been reported. Meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioedema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. A few cases of leukopenia, usually transient, have been reported following prolonged dosage. Rarely, cases of aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia have been reported; almost always, in the presence of known toxic agents.

Contraindications: History of sensitivity or severe intolerance to aspirin or meprobamate.

Composition: 150 mg. meprobamate, 75 mg. ethoheptazine citrate and 250 mg. aspirin per tablet.
Wyeth Laboratories Philadelphia, Pa.

Weighing on his mind, too

When pain evokes anxiety and tension, thereby heightening patient discomfort, a simple analgesic may only touch on part of the problem.

This single-prescription, non-narcotic product, however, usually provides effective analgesia and helps put the patient's mind at ease.

Health Officers of Cincinnati, Ohio And the Problems of Their Day

1900 to 1960

KENNETH I. E. MACLEOD, M. D., M. P. H.*

PART IX

(Continued from February Issue)

THE DISTRICT PHYSICIANS. The rate of attendance of indigents at the office remained as high or higher than in 1934, during 1935 and 1936, and also as many home visits were made.

During his third year as Acting Commissioner, Dr. Harder made note in his annual report in 1938 that "the diphtheria mortality rate of 1.5 per 100,000 was the lowest ever recorded" and "deaths from typhoid fever dropped from 9 to 6 during 1937." But tuberculosis is noted as remaining "a major public health problem." A chart of organization is given on page 5 of his report and shows eight divisions.

The flooding conditions in 1937 caused "the entire reserves of the department to be thrown into flood relief." [The complete report is on page 4 of the 1938 report.]

As the bulletin "goes to press" we announce: "The removal of the health center of the Cincinnati Department of Health to its new quarters, 212 West Twelfth Street." A picture of the health center is given on the frontispiece of Dr. Harder's Annual Report for 1938, published in August, 1939.

Dr. Carl A. Wilzbach: 1939-1960

Dr. Carl A. Wilzbach's term of office commenced in December, 1938. His appointment was noted as follows in the issue of CINCINNATI'S HEALTH dated August 1, 1939:

The position of Commissioner of Health was filled in December, 1938 after a lapse of five years through the selection by the Board of Health of Dr. Carl A. Wilzbach, a native Cincinnati who gained wide distinction in national, state, and local unofficial public health fields.

During Dr. Wilzbach's tenure of office many significant events took place, the most notable being World War II.

In the Inter-Chamber Health Conservation Contest held in 1939 by the U. S. Chamber of Commerce, Cincinnati was awarded "an award for meritorious achievement."

In his first annual report, Dr. Wilzbach noted a

significant new approach in the public health field, namely, that

the federal government began to subsidize state health work from Social Security funds in 1936. The use of the money was left to the discretion of the state health directors and in Ohio, the rural sections benefited mostly . . .

But "Cincinnati, like other cities, was allotted funds for a special syphilis control project."

The District Physicians: A noticeable falloff in home and office visits was noted from the high in the early 1930's.

In regard to reporting of tuberculosis, Dr. Wilzbach wrote pleadingly:

Please bear in mind tuberculosis should be reported by the physicians attending the cases. During 1938 in 123 instances tuberculosis was reported by death certificates.

But reporting of tuberculosis is not the only problem; even births were getting mislaid, for the frontispiece for the Annual Report for 1939 is a cartoon headed "Why Register Births." The answers in banners upheld by infants were these: "Birth Registration Is Our Protection: Parents, Can You Prove We Are Your Own?"

Vital Statistics — 1940

In 1940 the health of the city was summarized as follows:

Population: 455,610 of whom the nonwhite numbered 55,959.

Births: Total of 9,429 of whom 6,866 were resident births. Of the latter, 1,095 were colored.

Deaths: Total 6,948 of whom 5,837 were residents.

Infant Mortality: There were 395 infant deaths under the age of one year — 36.3 per 1,000 live births.

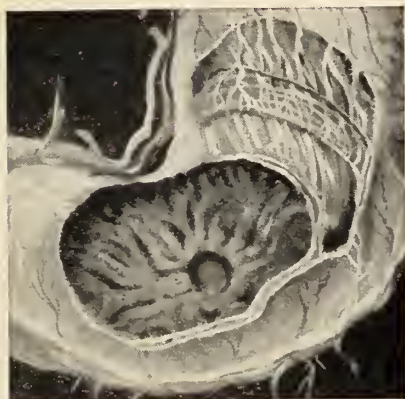
Maternal Mortality: The resident death rate from puerperal causes was 3.4 per 1,000 live births. For the whites 3.2, for the colored 4.5.

Tuberculosis: Was still among the ten leading causes of death, being in eighth place. (Diseases of

*Dr. Macleod, Cincinnati, is Commissioner of Health, City of Cincinnati.

Submitted March 16, 1966.

In peptic ulcer... antacid therapy with a new benefit



CONTAINS A BALANCED
COMBINATION
OF THE MOST WIDELY
USED ANTACIDS—
FOR RAPID
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PLUS SIMETHICONE—
TO CONTROL
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Composition: Each Mylanta chewable tablet or teaspoonful (5 ml.) of liquid contains: magnesium hydroxide, 200 mg.; aluminum hydroxide, dried gel, 200 mg.; simethicone, 20 mg. **Dosage:** one or two tablets, well chewed or allowed to dissolve in the mouth, or one or two teaspoonfuls of liquid to be taken between meals and at bedtime.

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Stuart

the heart was in first place where it has been since 1920.)

Typhoid Fever: 16 cases were reported (the lowest year was 1935 with 13 cases).

Gastroenteritis in Infants: The mortality from this cause had dropped to under 10 per 100,000 population since the mid 1930's but had leveled off.

World War II

The war years (1941-1945) note the stresses of wartime in an industrial economy geared to high overcrowding, and its effect in increased incidence of tuberculosis and other problems. Dr. Wilzbach makes frequent reference to these points during this devastating war. It can be summarized in one sentence from his report for 1942: "Collateral war efforts augmented the work of every Bureau of the Health Department . . ." The issue was dedicated to 15 members of the staff "who have entered U. S. Military Service . . ."

But the routine had to go on as the following excerpt from the Annual Report for 1943 indicates: Thirty-five court cases were handled during the year; 22 of these were for operating either a food establishment, or a barber shop or beauty parlor, without a permit . . .

The problem of psittacosis engaged the department. It is noted that

in cooperation with the United States Public Health Service and the State Department of Health, in 1943, 669 birds of the *Psittacine* family were inspected on arrival at local pet shops. Only birds from psittacosis-free aviaries are permitted in interstate commerce . . .

Health of City — 1945

The annual report for 1945 published in 1946 notes that

although the war ended in 1945, the public health problems it had created due to overcrowding, shortages of sanitary equipment, industrial health hazards, and the serious lack of health department professional personnel to cope with these problems continued through the year. Yet in view of these facts the city is fortunate to have come through the year with no serious epidemics . . .

The age of science and the wonder drugs is already telling. It is noted on the second page of the report: Decided advances were made during the year in the treatment and control of syphilis and gonorrhea. Persons with infectious syphilis found in public clinics receive adequate penicillin treatment in the hospital in 10 to 14 days. More than a hundred persons have been treated since the inception of the rapid treatment center. In the same fashion, penicillin is being used to treat gonorrhea . . .

Old Problems

And the old problem of rat infestation is being tackled anew with passage of Ordinance No. 608, whereby the Board of Health "enacted regulations outlining specifications for the compulsory rat-proofing of buildings . . ."

And the effect of the war on the birth rate is noted.

The total resident births up over 2 per cent since 1944.

The resident infant death rate declined to the lowest point ever in 1946. The deaths numbered 275 at a rate of 27.4 per 1,000 live births.

Among the items of progress during the year 1946 are noted: "The employment of a trained health educator, a graduate of the Michigan School of Public Health" and, "The third ten-year appointment of Dr. William Muhlberg to the Cincinnati Board of Health . . ."

Under the heading "Health Education" Dr. Wilzbach states:

Activities are carried on through daily news items, special articles for health and medical journals, radio broadcasts, special printed material and hundreds of health talks to organizations and groups . . .

That venereal disease was a problem during those days is clearly evident by this bald statistic:

Patients numbering 10,881 made 59,970 visits to all the venereal disease clinics of the department and received 70,148 treatments . . .

The heart clinic, operated on behalf of the department by Dr. Bernard Schwartz which is partially financed by the Max and Martha Stern Heart Fund, processed over 1,000 children.

Organizational Chart

A comprehensive organizational chart of the department, published in the 1947 report, indicates that seven bureaus were reporting to the Health Commissioner. They were: administration, nursing, health centers, medical services, laboratories, sanitary inspection, and dairy inspection.

In this annual report Dr. Wilzbach gives a synoptic review of progress since 1867, the year of the foundation of the department as a formal department. Among other items he notes that

The year 1947 marks the fiftieth anniversary of the founding and opening of the First Municipal Hospital for Tuberculosis in America; namely, the Cincinnati Branch Hospital, now the Dunham Hospital of Hamilton County . . .

Among other items of progress that same year he notes:

1. An ordinance effective January 1, 1948 was passed requiring the vaccination of all dogs, thus helping to control rabies in Cincinnati.

2. Since 1944, approximately 115,000 individuals have received chest examinations under the mass x-ray screening program which is conducted jointly by the Anti-Tuberculosis League and the Health Department.

But not all is progress, as a five year comparative table for the years 1943-1947 indicates in regard to "venereal disease delinquents failing to report for treatment . . ." The wonder drugs are not enough; education is also necessary and the cooperation of the public. Venereal disease is still a secret and despicable disease. It is not easy to have patients and physicians cooperate. This is still the case in 1964.

(Continued in April Issue)



Scientific Section

VOL. 63

MARCH, 1967

No. 3

Maternal Mortality Report for Ohio

A 10-Year Survey, 1955 - 1964*

By the OSMA COMMITTEE ON MATERNAL HEALTH

WITH a deep sense of pride, the Committee on Maternal Health presents its TENTH annual report. However, on this occasion, a unique goal has been attained, and a brief but illuminating survey of the features, facts and functions of the Committee in its Study of Ohio Maternal Deaths is both practical and timely.

Considering the enormous quantity of data and educational information accumulated by the Committee since 1955, this presentation can scarcely be delivered without recognizing the efforts expended by innumerable individuals who contributed richly to the project. The Committee on Maternal Health, cooperative agencies, and many individuals are commended for their excellent contributions to the Ohio Maternal Mortality Study in which the following material has been compiled over a 10-year period.

Background

Throughout Ohio over the past 30 years several individuals and groups have studied *maternal* deaths in a sporadic fashion. The first group of notable size was organized in the Cleveland area about 1932. Known as the Hospital Obstetrical Society of

Ohio, the band of obstetricians set out to collect data on maternal deaths from 40 or 50 Ohio hospitals. After studying and compiling data the group published its first report in 1938.¹ Information from hospitalized patients only was included in the study; today one can only surmise the hazards and difficulties encountered in those early days by this progressive group. After several years the study was abandoned due to the manpower demands of World War II.

It was not until 1948 that a systematic county-wide study of all maternal deaths (at home and in hospitals) was organized in Ohio. After carefully planning the project for nearly a year, Drs. Meiling and Ruppertsberg commenced the operation of The Franklin County Maternal Mortality Study, under sponsorship of the Columbus (Ohio) Obstetric-Gynecologic Society. Policies, criteria, questionnaire forms, liaison with hospitals and agencies initially developed in 1947 by the authors, yielded appreciable returns, but in spite of these plans, the cofounders met with isolated instances of strong opposition and personal prejudices. However, frequent assurance of policies providing anonymity and strict adherence to scientific evaluation of facts in each case, eventually overcame fears and suspicions of skeptical physicians. These problems, together with impressive statistical results in the first *five* years of the project were published by the authors in 1954.² The Franklin County Study continues in its *19th* year of operation. Details of the successful planning, organ-

*A continuous state-wide Maternal Mortality Study is being conducted in Ohio by the Committee on Maternal Health of the Ohio State Medical Association, in cooperation with the Ohio Department of Health, and assisted by representatives of the various County Medical Societies of the State. Since work of the Committee is educational as well as statistical, summaries of some of the cases studied by the Committee, based on anonymous data submitted, are published in *The Ohio State Medical Journal* from time to time. Each presentation is brief but informative. It contains opinions of the Committee, based on the data submitted for review.

ization and operation of the Franklin County Maternal Mortality Study were transmitted to enthusiasts in other areas who were searching for schemes to launch similar projects.³

Meanwhile, cofounders of the county study were in close contact with officials of the Ohio State Medical Association relative to prospects of organizing a state-wide Maternal Mortality Study for the 88 counties in Ohio. Cooperation and mutual assistance in launching the project were readily obtained from John D. Porterfield, M.D., (then) Ohio Director of Health, and his staff. The sponsor of this gigantic program was to be the OSMA. The initial committee, under direction of its President (Dr. Merrill D. Prugh), among others, included Drs. Meiling and Ruppertsberg. Almost to a perfect "overlay," the meticulous planning for the Franklin County Study was projected onto every county area in Ohio, utilizing the 11 Councilor Districts, OSMA, as dividing areas.

Committee Appointed

By action through a resolution adopted on the floor of the House of Delegates, OSMA, April 23, 1953, the project was initiated. Further action by The Council, OSMA, and the President on January 10, 1954, named members of the Committee on Maternal Health and authorized it to take necessary steps to set the mechanics of the study into motion.

After weeks and months of additional planning, the program was completed. Functions, policies and operations of the Committee were clearly defined. Collection of data on "Maternal Death Cases" throughout Ohio began January 1, 1955. The educational potential of the state-wide Maternal Mortality Study, together with full details of its operation (including functions of committees at County Medical Society level) were fully publicized.⁴

Terminology

The initial article contained clarification of terms and policies to be employed in The Ohio Study.⁴ Although these have been published previously, there is still occasional confusion regarding the use of our terms, in contradistinction to those of other localities. All maternal mortality studies in Ohio employ terminology prescribed by the "International Classification of Diseases, Illnesses and Causes of Death," as advocated by The World Health Organization (WHO).

Maternal, Nonmaternal Death

The term "*maternal death*" (obstetric death) includes all deaths in women with nonviable or viable babies dying during pregnancy, labor or the puerperium* from causes *directly* due to the pregnant state (abortion, ectopic pregnancy, placenta previa, eclampsia). The term also includes selected cases due *indirectly* to an obstetrical cause of death, where the pregnant state aggravated or exaggerated the

pre-existing or developing disease, thereby causing death (heart disease, diabetes, hypertension with cerebrovascular accident).

When pregnancy and labor have *no connection* with the death, the case is voted a "*nonmaternal*" (nonobstetric) death (external trauma, homicide, etc.). In order to evaluate and classify cases properly each case is presented anonymously, studied by the Committee, and voted into its proper category.

In the study of *each* case, members of the Committee analyze the cause of death, the factors in its management and then assess responsibility, enumerating the preventable or avoidable factors, e.g., a "*nonpreventable*" maternal death is classified as an "*unavoidable catastrophe*!" Therefore, the duty of the Committee rests in culling out *all* of these factors from the information which is available. Likewise, the Committee determines the *primary* cause of death. In many cases there are *several* conditions to be classified as *contributing* causes of death. Frequently an autopsy provides the sole differential factor with which the Committee classifies the case.

Progress

The Committee on Maternal Health, was assigned *three* functions: To conduct a systematic, continuous, scientific *study* of all maternal deaths in Ohio; to maintain an educational program for Ohio physicians pertaining to the practice of Obstetrics; to act as an advisory body to The Council, in matters pertaining to "Maternal Health in Ohio."

Coordination of Committee functions with County Medical Societies, numerous organizations, hospitals and agencies throughout the state was tedious but rewarding. Eventually the purpose of the study and enthusiasm of Committee members reflected throughout Ohio.⁵

Physicians were periodically apprised of the progress of the program through articles published by the Committee, in *The Ohio State Medical Journal*. A special column titled "Maternal Health in Ohio" was reserved for information prepared by the Committee. Anonymous case reports with comments of the Committee, together with statistics and pertinent educational items filled this space on a regular schedule.

Through the use of a preferred mailing list, reprints of these articles are distributed to more than 200 interested individuals and agencies over the United States; the list also includes physicians in Canada, Ireland and as far west as Australia. Recipients indicate their opinions with comments and criticism, most of which are extremely favorable. To date over 90 of these articles have been published in this column.

In studying maternal death cases the Committee found the need for a set of minimum standards, to provide a "yardstick" for use in determining whether or not a given patient received adequate obstetrical

* (Death within 365 days of delivery, or abortion.)

care. For approximately three years, members labored to develop a simple, yet efficient set of recommendations for use by both physicians and the Committee. The completed document was approved by The Council, and was published as "Guiding Principles for Obstetric Care"⁶ in 1957. Two small revisions have since been added.

To date, the Committee on Maternal Health has held 46 meetings. The budget allowed for the Committee by The Council is \$1,500 per year; expenditures over the 10 year period averaged \$1,423.56 per annum. These include costs of educational exhibits, mileage for travel of Committee members, data processing, printing, etc. All costs for the support of the Ohio Study and its Committee are borne by The Ohio State Medical Association. There have been no funds received from State, Federal or outside sources, to date.

Information concerning the innumerable activities and accomplishments of the Committee during the past years have been published frequently; they need not be reviewed at this point.⁷ However, it is desired to emphasize that the Committee supports well-established county maternal death studies operated in

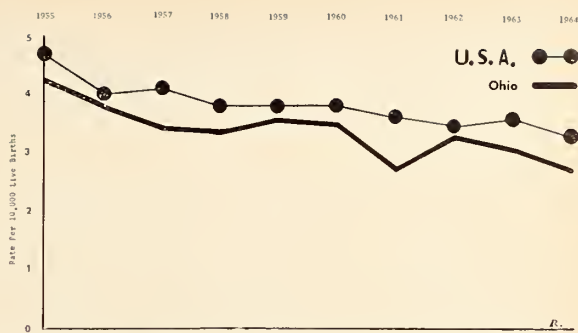


FIG. 2. *United States, and Ohio Maternal Mortality Study, Maternal Mortality Rates per 10,000 Live Births, 10 Years, 1955-1964.*

Cleveland, Columbus, Cincinnati, Dayton, Toledo and Akron. These projects, conducted by respective obstetric-gynecologic societies, serve to elicit data concerning maternal deaths, study cases, provide local educational media and transmit duplicate case reports for inclusion in the Ohio Study.

Scope of the Survey

In order to facilitate the comparison of features and statistics from the Ohio Maternal Mortality Study with those of other similar areas⁸⁻¹² the following format is utilized.

The maternal death rate in Ohio has followed a rather unusual but progressive decline, over the past three decades. In an *earlier period*, 1935 to 1955 (before the Ohio Study) the Ohio Maternal Mortality rate dropped from an alarming high rate (61.7 per 10,000 live births) to a much more acceptable rate (4.0 per 10,000 live births) shown in Fig. 1. Maternal deaths were generally elevated during this period; for example in 1935, the official maternal death rate reported by Columbus (Health Dept.) was 9.1 per 1,000 live births (91 per 10,000!).²

With the advent of the Ohio Maternal Mortality Study, beginning January 1, 1955, the maternal death rate pursued a general but less dramatic decline, principally because maternal death cases not heretofore recorded in Ohio Vital Statistics records, were discovered in local areas and included as cases in the study. The explanation of this is quite simple and relieves the Vital Statistics office from any undue criticism: (other) causes of death, listed occasionally on the standard certificate of death would contain no information or relationship to the pregnant state. Examples are: "Diabetes," "Congestive Heart Failure," "Chronic Renal Disease, Hypertension," all in the pregnant or puerperal patient.

The graphs comparing the U. S. A. maternal death rates and those obtained from The Ohio Study (Fig. 2) are rather similar, yet despite elevation due to accuracy, the Ohio rate is constantly below the national rate, for the 10 years reported.

Since it is estimated rather accurately, that physicians in general and family practice, deliver the

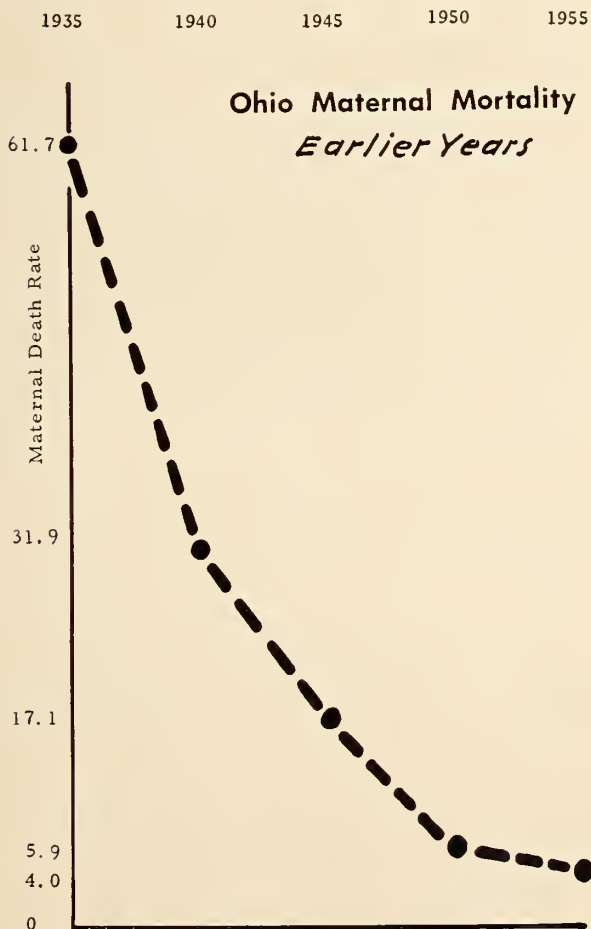


FIG. 1. *Ohio Maternal Death Rate, per 10,000 Live Births, for Five Selected Years, 1935-1955. (From Annual Vital Statistics Report in Ohio, 1960, Table 9, Page 11.)*

great majority of pregnant patients in Ohio each year, the Committee credits them with improvement in care, techniques and therapy among pregnant women, over this period of time. They are to be congratulated!

Analysis

Innumerable, fascinating statistics are available from the first decade of The Ohio Maternal Mortality Study through the IBM System of Data Processing. A total of 1080 maternal death cases were collected during the period being reported (Table 1). Due to lack of information, 48 cases are incomplete, under further investigation, while 27 cases initially be-

TABLE 1. *Classification of 1080 Cases, Ohio Maternal Mortality Study, 10 Years, 1955-1964.*

Total Cases in Files, 10 years	1080
Cases Not Studied Due to Lack of Information	48
Nonmaternal Deaths ..	221
Maternal Deaths	779
Undetermined Cause of Death	5
Cases Rejected From Study (No Case)	27
Total	1080

lieved to be "maternal cases" are proven to be non-applicable, e.g., death occurred in excess of 365 days of postpartum, etc.

The Committee studied and classified 221 cases as *nonmaternal* (nonobstetric), and 779 cases as *maternal deaths* (obstetric deaths) while five cases provided an *undetermined* cause of death after autopsy and could not be classified. Of the *five*, two died undelivered (one at 28 the other at 32 weeks gestation), while the remaining three died in from 9 to 12 weeks following a cesarean section, a low forceps delivery, and a spontaneous delivery, respectively.

During the 10-year period of this survey, Ohio reported 2,300,535 births (viable gestations) of which 33,786 were fetal deaths (stillbirths); some of the maternal deaths delivered a stillborn fetus (Table 2). The Ohio Maternal Mortality rate has shown a progressive decline for this decade, as mentioned previously (Fig. 2) from 4.31 to 2.81 per 10,000 live births. Considering the continued annual decline in number of Ohio live births since 1954, the diminution in the annual maternal death

rate is even more significant! This has caused a real problem in the maternity bed occupancy throughout Ohio hospitals.¹³

Cause of Death

In order to establish and maintain a program of education and information it is essential to study the variety and number of *maternal* (obstetric) deaths, as well as the *nonmaternal* (nonobstetric) deaths. Data on the former group are presented in this survey; statistics on the latter group will be reviewed in a future article.

HEMORRHAGE. Analyzing the primary cause of 779 maternal deaths during the 10-year period (Table 3) it is evident that *hemorrhage* led all major causes with 206 cases (26.4 per cent). Inspecting statistics for each year, it was surpassed in only two years (1961 and 1964) by the number of maternal deaths due to infection. A study of the contributing factors causing death due to *hemorrhage* (Table 4) reveals the leading cause, *Ruptured Uterus*, 63 cases (31.3 per cent). Only nine revealed rupture after Pitocin® administration; 11 had had previous cesarean sections; eight had previous "uterine surgery"; 16 ruptured after a difficult breech extraction (nine preceded by version); 10 suffered rupture after "difficult forceps" delivery, and nine had spontaneous rupture. Only 4 of the 63 deaths from ruptured uterus were voted *nonpreventable*.

Of the 206 maternal deaths from hemorrhage, 25 were dead on arrival (DOA) (12.1 per cent); 17 of the DOA patients died from ruptured ectopic pregnancy. Forty of the 206 maternal deaths from hemorrhage (19.4 per cent) resulted from *ectopic pregnancy*; well over half of these (28) were not operated upon. *Afibrinogenemia* (following abruptio placenta, amniotic fluid embolism, and fetal death) accounted for 35 of the 206 deaths from hemorrhage (Table 4), while hemorrhage secondary to *uterine atony* accounted for another 22.

The list of 15 *other contributing factors* is too long and varied for inclusion in the space allotted for this survey. Suffice it to mention, *causes* culminating in hemorrhage and death include an array from ruptured splenic artery, and ruptured ovarian

TABLE 2. *Ohio Live Births, Stillbirths, Maternal Deaths and Maternal Death Rates, 10 Years, 1955-1964*

Year	Live Births*	Stillbirths*	Maternal Deaths**	Maternal Death Rates per 10,000 Live Births
1955	222,689	3,736	96	4.31
1956	234,517	3,682	92	3.92
1957	243,470	3,655	85	3.49
1958	234,040	3,535	81	3.46
1959	232,578	3,564	85	3.65
1960	230,219	3,347	81	3.52
1961	229,708	3,171	64	2.79
1962	217,465	3,155	72	3.36
1963	212,583	2,988	64	3.01
1964	209,480	2,953	59	2.81
Total.....	2,266,749	33,786	779	

*From Bureau of Vital Statistics, Ohio Department of Health

**From the Ohio Maternal Mortality Study

TABLE 3. *Primary Causes of Maternal Death, Ohio, Yearly, 10 Years, 1955-1964*

Cause	1955	1956	1957	1958	1959	1960	1961	1962	1963	1964	Total
Hemorrhage	17	24	26	17	22	25	17	21	25	12	206
Infection	14	12	12	16	16	16	18	18	14	21	157
Toxemia	11	17	9	14	4	11	2	8	4	6	86
Other*	54	39	38	34	43	29	27	25	21	20	330
Total.....	96	92	85	81	85	81	64	72	64	59	779

*See Table 5

vein, to postabortal hemorrhage following spontaneous abortion in a cervical pregnancy! A number of these have been published previously.¹⁴

INFECTION. With 157 (20.1 per cent) of the 779 maternal deaths, infection was second, in number of primary causes of maternal death (Table 3). Over one-half of these 157 maternal deaths (89) followed abortions, of which three fourths were alleged "criminal." Similar statistics (including septic shock) have been analyzed in an article comparing figures from The Ohio Study with data from the maternal mortality studies conducted in Minnesota, Massachusetts and Wisconsin.¹⁵ (Indeed this co-operative transfer of information and data, between maternal death studies of various states provides a pertinent educational medium, and should be em-

ployed more frequently.) Approximately 23 per cent of the 89 cases developed "septic shock"; one fourth of the patients developed terminal septicemia and died in spite of antibiotic therapy, which was often (a) started too late, (b) administered in doses therapeutically too small, or (c) was proven to be a drug to which the causative organism was not sensitive!

The bizarre and shocking histories connected with "criminal" abortion are often puzzling to the Committee: one 27 year old colored, para III, took quinine by mouth in her second month, then inserted a "slippery elm" into her cervix; she developed a fulminating peritonitis, lower nephron nephrosis and died in 23 days. Another, a 25 year old, colored, para I, "had a tube inserted into the womb" in her 10th week of gestation; she developed septicemia, "septic shock" and died two days later. *Clostridium Welchii* was found in a blood culture. A third patient, 33 year old, white, gravida IV, para III, "inserted a catheter" during the 13th week of pregnancy; through the catheter she injected a mixture containing 30 cc. of mineral oil, 1 cc. of organic iodine compound, 0.5 Gm. streptomycin, 100,000 units penicillin and 100 mg. Terramycin®. Half an hour later she vomited "iodine tasting material," developed dyspnea, cyanosis. Admitted two days later with pulmonary edema, she developed oliguria and died two days later, in spite of heroic therapy.

Observations from septic cases in the Ohio Study correspond favorably to those advocated in the Minnesota Study,¹⁰ e.g., "antibiotics are not a panacea for troubles stemming from the disregard of basic obstetric principles of management." All "criminal abortions" are voted preventable maternal deaths!

Emboli and thrombotic phenomena are considered separately under "other causes" (Table 5). Unlike experiences quoted in the Minnesota Study, in Ohio only two upper respiratory infection (URI) deaths were associated with "Asian Flu" in 1957; seven more of these completed a total of nine "URI" deaths, over remaining years.

TOXEMIAS. Third in the "triad" causing the majority of maternal deaths were those from *toxemia*, which accounted for 86 (11.0 per cent) of the 779, for 10 years (Table 3). During the last four years, deaths from toxemia diminished to an all-time low in this survey. Of the 86 maternal deaths, 11 patients had *no* prenatal care, 26 had *inadequate* prenatal care, but 45 had *adequate* care; on the re-

TABLE 4. *Contributing Factors, 206 Maternal Deaths Due to Hemorrhage, Ohio Maternal Mortality Study, 10 Years 1955-1964.*

Abortion	4
Abruptio Placenta	7
Afibrinogenemia, after abruptio	19
" " , after Amn. Fl. Embolus	10
" " , after Fetal Death	6
Atony, uterine, postpartum	22
Ecotopic Pregnancy	40
Laceration, extrauterine	12
Placenta Previa	6
Retained Placenta	2
Ruptured Uterus	63
Other	15
Total	206

TABLE 5. *Other Primary Causes of Maternal Deaths, Ohio, 10 Years, 1955-1964.*

Cause	Number of Cases
Amniotic Fluid Embolism*	27
Anesthesia, General	36
Anesthesia, Regional	25
Cardiac Arrest	5
Cardiac Disease	57
Cerebrovasc. Hemorrhage (No Tox.)	16
Chorioepithelioma	5
Diabetes	9
Embolism, pulmonary	82
Liver Disease	6
Lower Nephron Nephrosis	19
Mole, Hydatid	2
Renal Disease	8
Shock (trauma, incl. Inv. Uterus)	5
Pulmonary Edema	9
Ileus, paralytic, intestinal	3
Uremia	3
Other, remaining	13
Total	330

* (No Afibrinogenemia)

maintaining four the antenatal attention was not reported. One fifth of the patients had "excessive weight gain" (over 35 lbs.). The Committee voted 55 of the 86 maternal deaths from toxemia as preventable. Failure of patients to seek and continue prenatal care, and a lack of prompt, efficient treatment of severe hypertension and impending eclampsias were considered avoidable factors.

Other Causes

Within this group of miscellaneous "primary causes" of maternal deaths are classified 330 cases which (by our definition) *should* have a place in the "International Classification." However, in policy and precedent we agree with concepts of other similar maternal death studies.¹⁰⁻¹² Since we seek to study cause, evaluate management, and assess responsibility in maternal deaths, we continue to place these miscellaneous causes in a separate category (Table 5).

Four of the predominant "other causes" are discussed:

Pulmonary Embolism led this group with 82 (24.8 per cent) of the 330 maternal deaths. The Committee voted 58 of these cases nonpreventable deaths (unavoidable catastrophies). Of the 82 cases, 10 died as a sequella to thrombophlebitis; 5 were associated with a preceding thrombosis, and the remaining 67 followed an initial sepsis.

Anesthesia accounted for 61 maternal deaths. With some difficulty (due to use of one or more anesthetic agents on the same patient) these were divided into *general* anesthesia (36 cases) and *regional* anesthesia (25 cases). Of the former, 29 patients received inhalation anesthesia while seven received an intravenous agent (Pentothal®). Under regional anesthesia, 17 patients received spinal while *eight* received "saddle" type medication.

The majority of deaths under inhalation type resulted from "aspiration" and "poor ventilation (oxygenation)" complications. Spinal anesthetics were usually complicated by an initial, severe arterial hypotension; the same held true in the "saddle" type, except that two of the eight revealed an allergic reaction to the medication employed. In two cases, the Committee felt that the dosage of medication used in "spinal" anesthesia should have been reduced to be adapted by the pregnant patient. These findings coincide with reports of other studies.^{10,12} Only one case of the 61 was voted a nonpreventable death. Promoted by the Committee, the Ohio Society of Anesthesiologists has sponsored and prepared an excellent educational program in OB Anesthesia for Ohio physicians.

Cardiac Disease was the next most prevalent cause of maternal death in this group with 57 cases. Forty-five (78.9 per cent) of the patients had a definite history of cardiac disease, nine of whom were "congenital." The remaining 12 died of cardiac

failure, preceded by another pathologic process during pregnancy. Of the 57 maternal deaths, the Committee voted 29 nonpreventable. Usually there is a failure to watch the patient more carefully during the 32nd to 38th week of gestation, and for a period of four to six weeks postpartum, both phases representing the most critical periods for cardiac adaptation and adjustment.

Amniotic Fluid Embolism: This calamitous complication of labor accounted for 27 deaths (8.2 per cent) of the 330 in this category. All but one of the 27 had membranes ruptured; six of the 27 had had "Pitocin"® administered followed by violent labor and catastrophe.

Miscellaneous Other Causes: Briefly, in scanning the balance of this long list of primary causes of 330 maternal deaths a few items bear further explanation.

- 1. Lower Nephron Nephrosis, accounted for 19 maternal deaths. Although this is indeed a primary cause of death, it occurs secondary to a profound primary pathologic process; 11 of the 19 deaths due to lower nephron nephrosis, "followed initial hemorrhage." Two patients were believed to have suffered a "transfusion reaction," while the remaining six developed "renal shutdown" following eclampsia (two), and massive infection (four) — two of which developed septic shock.

- 2. Chorioepithelioma caused five of the 330 deaths in this category. Three of the five followed abortion, one gave history of a previous "mole" (postabortal), one followed an ectopic pregnancy, and none was preceded by a term pregnancy. Exclusive of the ectopic pregnancy, two of the patients died from 7 to 28 days postabortal, while the other two had an interval of 6 to 12 months between abortion and death. (This feature supports our use of a "365 day puerperium" for the purpose of case collection.) All five cases were voted nonpreventable maternal deaths.

- 3. Inverted Uterus. Puerperal inversion, although uncommon, accounted for *five* maternal deaths; four demonstrated signs of shock while one death was preceded by shock secondary to hemorrhage. Although these cases have been published previously,¹⁷ all five cases were voted preventable deaths. Postpartum exploration of the uterus was performed in only one of the five patients, while in one instance, the diagnosis was not discovered until an autopsy was performed.

- 4. *Other Primary Causes (Specified):* This category in our coding system for maternal deaths includes the somewhat unusual diagnoses. Three cases are worthy of explanation:

- a. Cause of death: "Cardiovascular accident with terminal toxemia, hypertension and obesity." The patient died 12 to 24 hours postpartum; there was

no premedication or anesthesia and delivery was spontaneous. Autopsy was performed.

b. One died undelivered. Cause of death: "Massive gastric hemorrhage, accidental aspiration of vomitus, hemorrhage, shock, abruptio placenta." There was an autopsy.

c. Cause of death: "Accidental anoxia, cause of death not actually confirmed" (coroner's autopsy). Term pregnancy in a para V, spontaneous delivery. Slight edema responding to therapy during the pregnancy was the sole complication reported.

- 5. *Suicide*, as a cause of maternal death appears infrequently in this survey with only two cases, included in "other causes." Although several more cases with a diagnosis of "suicide" were studied during the 10 years, the Committee voted them *nonmaternal* deaths (no connection to the pregnant state). The psychiatric aspects of several cases have been published previously together with case reports.¹⁸ Often, members of the Committee found difficulty in assessing pregnancy either as an exaggerating or primary factor in the eventual diagnosis.

- 6. Blood Dyscrasias. Likewise there arose a problem in the classification of *maternal* deaths due to blood dyscrasias per se. There were only two cases coming under this diagnostic heading as a cause of death; one bore a diagnosis of acute myelogenous leukemia, the other, thrombocytopenic purpura. Actually both patients died of hemorrhage but this subclassification was established to differentiate these (as an entity) from cases of obstetric hemorrhage. The leukemia patient, in a remission stage was transferred (pregnant) to a "center," delivered spontaneously, bled afterwards, had a curettage, continued to bleed, submitted to a vaginal hysterectomy and finally died five weeks postpartum in spite of transfusions and all types of therapy.

DOA — Autopsies

Among the 779 maternal deaths, 69 (8.9 per cent) were dead on arrival at hospital emergency rooms. In categories of primary cause of death, 25 were due to *hemorrhage* (including 17 ectopic pregnancies); 10 were due to *infection* (including seven criminal abortion cases); *toxemia* accounted for nine (including four each with eclampsia and cerebrovascular accident due to hypertensive vascular disease) and 25 from "*other causes*" (the majority including 13 from pulmonary embolism). These statistics are similar to those published in other studies.^{11,12}

Autopsies were performed upon 566 (72.6 per cent) of the 779 maternity patients who died. One hundred twenty-seven of the autopsies were "coroner's cases." While the number of maternal deaths diminished gradually year by year, the number of autopsies obtained remained about the same; thus the autopsy rate increased.

Place of Death

In one phase of the 10-year survey an effort was made to examine the data for county-area and exact

TABLE 6. *Place of Death, 779 Maternal Deaths, Ohio, 10 Years, 1955-1964.*

(County) Areas	Hospital	Home	Other	Total
Cleveland	139	14	9	162
Columbus	87	7	2	96
Cincinnati	80	5	0	85
Toledo	41	4	2	47
Dayton	43	3	2	48
Akron	32	3	1	36
Other Areas	281	21	3	305
Total	703	57	19	779

TABLE 7. *Type of Delivery 779 Maternal Deaths, Ohio, 10 Years, 1955-1964*

Type	Number
Not Recorded	11
Operative	387
Non-operative (Spontaneous)	222
Not Delivered (Died undelivered)	159
Total	779

status of each patient as to her location when she died. Within the 779 maternal deaths, only 76 (9.7 per cent) died *outside* of a hospital (Table 6). However, this single feature supports the contention that *all possible maternal death cases* must be collected for consideration in the county studies; acquisition must not be confined to patients dying in hospitals.

In our next phase we examined the statistics for the number of maternal deaths which occurred in (six) county areas where well organized regional maternal mortality studies were operating on an annual basis. As anticipated, the great majority of cases in the study (139) came from the Cleveland area (Cuyahoga County), largest metropolis in Ohio, (Table 6). Comparative maternal death *rates* together with urban and rural environmental effects will be the subject of a future article.

Type of Delivery

A glance at Table 7 provides the reader with an analysis of the type of delivery among 768 maternal deaths, excluding a small segment of 11 cases discarded. Most of the latter were among abortions in which all data (before admission) was not available.

Perhaps a technical point in operative vs. non-operative delivery bears explanation; if a patient delivered the product of conception *without* action on the part of the attendant, the delivery was *spontaneous* (nonoperative). All others (extraction, forceps, cesarean section, etc.), were considered *operative* deliveries, *except* where a breech presentation was merely *assisted* (not extracted).

Six hundred nine of the 768 cases reported (79.2 per cent) were delivered, while 159 died undelivered. In the group of ectopic pregnancies the patients in the latter class were *not* operated upon.

Prenatal Care, Child Outcome

The emphasis placed upon adequate prenatal care during obstetric practice today needs no reiteration.

The dire importance of *adequate* care of the pregnant patient likewise is paramount among physicians in Ohio, as elsewhere. Minimum standards defining specific principles and procedures have been developed and are readily available.⁶ The specific relationship of prenatal care and maternal deaths due to toxemia have been described (above). However, in the Ohio Study, the incidence of *live births* among mothers who have received *adequate* prenatal care is markedly higher than among mothers who had inadequate prenatal care, or none at all.¹⁶

Preventability, Responsibility, Avoidability

In any maternal mortality study operating successfully today the basic philosophy of the project *must* encompass one simple theorem: Through the scientific study of the cause of death, management of the pregnant patient and evaluation of all factors contributing to her death, information gleaned from this maternal death may be used to prevent another patient from dying from a similar cause in the future.

To this end the Committee studies every case, considers the cause of maternal death and specific factors in the patients' management. After evaluating all information available in the case, members designate *responsibility* for errors, omissions and inadequacies on part of the patient (P_1), personnel (P_2) or miscellaneous area (P_3 , hospitals, agencies, etc.). The *preventability* of the death is then evolved; facts in the death are adjudged in the ideal academic sense, based upon a level of ideal obstetric care.⁶ Avoidable factors are assessed for use in the educational program.

In Table 8 the results of Committee deliberations in the 779 maternal deaths are tabulated. Thirty-five per cent of the cases were classed as *nonpreventable*, "unavoidable catastrophies," while personnel responsibility (P_2) was present in one third (33.1 per cent) of the deaths. Miscellaneous factors (15) included a nonavailability of drugs, blood, 24 hour x-ray service, etc. As the Ohio Study progresses, it is evident that the *personnel* factors (P_2 , interns, residents, physicians, nurses, etc.) are diminishing each year. This feature establishes a credit to the profession, as mentioned above.^{7, 14, 13}

Statistics for 1964

Briefly a summary of statistics for the last year of the decade-survey, 1964, is presented. Pursuant to

TABLE 8. *Preventability, Distribution of Avoidable Factors, 779 Maternal Deaths in Ohio, 10 Years, 1955-1964*

Factor	No. of Cases	%
Nonpreventable	275	35.4
Preventable:	504	64.6
Patient (P_1)	146	
Personnel (P_2)	258	
Patient and Personnel (P_1 & P_2)	85	
Miscellaneous Factors (P_3)	15	
Total	779	100

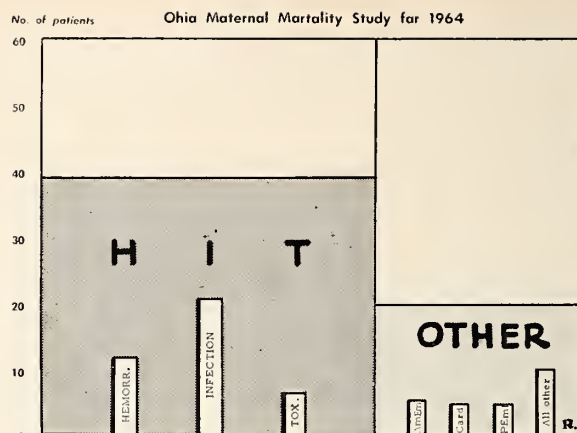


FIG. 3. *Classification of primary causes of death, 59 maternal deaths for 1964.*

directions of The Council, January 16, 1954, in approving functions of the Committee on Maternal Health, Annual Reports are made to OSMA members through THE JOURNAL. These documents have been published annually, 1955 to 1963, inclusively. Since the initial publication of these reports (year by year), the Committee has completed and added 40 more maternal deaths to the series, all included in Table 2, and Fig. 4.

Ohio Maternal Mortality Study Statistics for 1964

Total Live Births in Ohio, 1964	209,480
(Total Cases in files, 10 years, 1955-1964...1080)	
Total Cases Studied (1964)	86
Cases not studied due to lack of information	6
Undetermined	0
Maternal Deaths (Classified)	59
Non-white	18
White	41
Age:	
Teens	2
20's	32
30's	21
40's	4
Parity:	
Primigravidae	16
Multiparae	38
Unknown	5
Place of Death:	
Hospital	57
Home	1
Other	1
Type of Delivery:	
Not Recorded	3
Operative	31
Nonoperative (spontaneous)	15
Not delivered	10
Route of Delivery:	
Not Recorded	1
Vaginal	31
Cesarean (antemortem)	15
* (Postmortem)	0
Laparotomy (ectopic Preg.)	2
*Not delivered	10
Case Classification: (when death occurred)	
Not known	4
Group I (fr. concept to 20th wk.)	0
Group II (fr. 20th wk. to 28th wk.)	3
Group III (fr. 28th wk. through term)	3
Group IV (postabortal, postpartum)	49
Autopsies:	49
(includes 13 coroners' cases)	
Prenatal Care: (apparent from data sheets)	
None	8
Unknown or not reported	7
Adequate	30
Inadequate	6
Excluded (ectopic Preg. and abortion)	8
Classification of Preventability:	
Nonpreventable	20
Preventable (avoidable factor)	39
Patient responsibility (P_1)	15

Personnel responsibility (P ₂)	19
Both P ₁ and P ₂	5
P ₃ (Misc.)	0

Classification of Primary Causes of Death:

Hemorrhage	12
Afibrinogenemia	1
Abruptio	1
Atony, uterine, postpartum	3
Ectopic pregnancy (without sepsis)	2
Placenta Praevia	1
Retained Placenta	1
Ruptured uterus (no afibrin.)	2
Other	2
Infection	21
Abortinn, alleged "criminal"	7
Abortion, septic, spontaneous	3
Peritonitis	4
Septicemia (puerperal sepsis)	3
Septicemia (other)	2
Up. Resp. Inf.	2
Toxemia	6
Hypertension, chronic (incl. Hyperten-	
sion with cerebrovascular hem.)	3
Eclampsia	2
Renal Disease	1
Other	20
Amniotic fl. emb. (no hemorrhage)	4
Anesthesia	1
(general)	1
(regional)	0
Cardiac Arrest	1
Cardiac Disease	3
Chorioepithelioma	1
Diabetes	1
Dyscrasia	1
Liver Disease	1
Lower Nephron Nephrosis	1
Mole, Hydatid	1
Pulmonary Edema	1
Pulmonary embolus	3
Renal disease, chronic, unspecified	1

In Ohio, there were 209,480 live births reported during 1964. From this maternal mortality study, the Committee classified 59 *maternal* deaths for the year. The maternal mortality rate was 0.28 per 1000 live births, or 2.81 per 10,000 live births for 1964.

The Committee is proud to publish this report since it represents a *low* maternal death rate (2.81 per 10,000) improved only by the one published for 1961 (2.79 per 10,000) in Table 2. Previously stated, this reflects a real tribute to Ohio physicians who practice obstetrics. Figure 3 graphically depicts the comparative distribution of primary causes of death in the 10th year of the survey. Perhaps the most distinctive alteration in distribution of primary causes of death appears as *hemorrhage* (leading cause in 59 cases) is surpassed in its 12 maternal deaths by *infection* (21 cases). Only once before (in 1961) did this occur during the decade.

Criminal abortion accounted for one third of the 21 maternal deaths from *infection*; peritonitis caused another four fatalities. Toxemia caused only six of the deaths, while amniotic fluid embolus and pulmonary embolus were most predominant among "other causes." Thirty of 44 patients reported, received *adequate* prenatal care; 66.1 per cent of the maternal deaths were voted *preventable*.

Summary

1. A ten-year survey of maternal deaths in Ohio from 1955 to 1964 (covering a decade) is presented by the Committee. Briefly, pertinent statistics for the 10th year (1964) are published, inclusively.

2. An historical background of the organization, development and functions of the Ohio Maternal

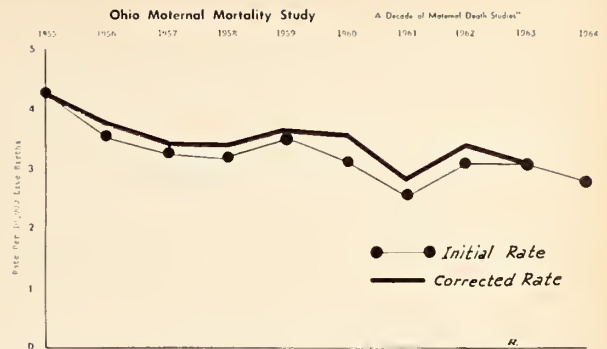


FIG. 4. Ohio Maternal Mortality Rate per 10,000 Live Births, 10 Years, 1955-1964, from the Ohio Study, (See text).

Mortality Study by the Committee on Maternal Health (OSMA) is related. Problems and progress are discussed, together with policies and terminology used throughout the state.

3. During the decade 1080 cases in the study were examined. Thorough evaluation by the Committee resulted in classifying 221 *nonmaternal* deaths and 779 *maternal* deaths (Table 1).

During the period of the survey, Ohio reported 2,300,535 births, of which 2,266,749 were live births; 33,786 fetuses were stillborn (fetal deaths), Table 2. The maternal death rate diminished from 4.31 per 10,000 to 2.81 per 10,000 live births in the 10 years.

4. Analysis of the 779 maternal deaths reveals hemorrhage, infection, and toxemia (the "Three Fatal Horsemen") accounting for 57.5 per cent of the maternal deaths, Table 3. (a) Hemorrhage alone is responsible for 26.9 per cent of the cases; ruptured uterus contributes 63 of the 206 maternal deaths due to hemorrhage, comparable to statistics in other studies.¹⁰ All but four of the 63 cases are voted preventable. Seventeen of 40 deaths from ectopic pregnancy are dead on arrival. (b) Of the 157 deaths due to infection, 89 are associated with abortion, three fourths of which are criminal. *All* of the latter are voted preventable maternal deaths. (c) Of the "triad" (H-I-T), toxemias take third place with 11 per cent of 779 maternal deaths; prenatal care and its effect on prevention are discussed. (d) Under "Other causes of Maternal Death" the following are presented and discussed: Amniotic fluid embolus; anesthesia; cardiac disease; chorioepithelioma (5); lower nephron nephrosis; pulmonary embolus; inversion of the uterus; dyscrasias and suicide. (e) The autopsy rate in 779 maternal deaths is 72.6 per cent; 90.3 per cent of the patients died in hospitals. One hundred fifty-nine died undelivered. (f) Preventability of the 779 maternal deaths is 64.6 per cent, resulting from a vote of the Committee, after a careful study of each case. Preventable factors

are assigned to personnel in 258 of the 779 cases, Table 8. Features of avoidability are discussed.

5. Briefly, statistics and a summary of the Ohio Maternal Mortality Study for 1964 (the 10th year) are presented. In this report a maternal mortality rate of 2.81 per 10,000 live births is established. The number of maternal deaths for 1964 is the *lowest* of any of the ten consecutive years; facts and features of the 59 cases are discussed.

Recommendations

- 1. The Committee heartily recommends that the Ohio Maternal Mortality Study be continued, with increased effort to reduce further the maternal morbidity and mortality in Ohio. Although an attitude of pride can be justified in its research and educational facets, complacency must not be entertained lest the reduced trend of maternal deaths in the 10 year survey be reversed.

- 2. Educational features connected with the dedicated efforts of the Committee must be expanded. A program of information and education should continue to focus upon factors causing maternal deaths, and their prevention. More seminars, conferences and exhibits along this vein should be planned and implemented with the support of The Council, and county medical societies throughout the state.

- 3. It is recommended further, that the Chairman and Committee members renew efforts to coordinate and compare both activities and statistical data associated with the Ohio Study, with similar studies of other states. Valuable information and data obtained through mutual transfer will be of invaluable assistance in support of a program for education.

- 4. Advisory functions of the Committee with The Council, Ohio Department of Health, and other selected agencies on matters pertaining to maternal health should be continued, and augmented if the need appears.

With sincere appreciation, the Chairman acknowledges the loyal support of the Committee members who performed their duties effectively, conscientiously,

during the decade of this survey. And on behalf of the Committee, the Chairman gratefully acknowledges assistance provided by The Council, attending physicians, representatives of various county medical societies, the Ohio Department of Health and many other agencies and individuals. Without their untiring cooperation and efforts this Maternal Mortality Survey could not have been completed.

Respectfully submitted,

ANTHONY RUPPERSBERG, JR., M.D., *Chairman, Committee on Maternal Health*

Approved by The Council of the Ohio State Medical Association, December 11, 1966.

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The Problem of the Dizzy Patient

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ALMOST every doctor is confronted from time to time with the patient who complains of dizziness. The symptom is important, because, although it may indicate something as simple as fatigue, it may also be the symptom of a tumor. Confusion exists as to how to handle the dizzy patient, and a search of the literature reveals few articles dealing with the problem. This paper is written to help the doctor catalogue dizziness and to present a useful system of diagnosis and treatment.

Anatomy

The inner ear consists of an osseous labyrinth protecting a membranous labyrinth with its nerve endings (Fig. 1).

The osseous labyrinth is divided into two parts, the posterior part, consisting of the vestibule and semicircular canals, and an anterior part, the cochlea.

The membranous labyrinth is enclosed within the osseous labyrinth and has parts similar to the latter, except that it differs in the vestibule. Here there are two parts instead of one vestibular cavity; these are the utricle and the saccule. The fluid in the osseous canals is perilymph and in the membranous canals it is endolymph. The ampullated ends of the membranous canals contain the functioning parts of the canals. These consist of a group of neuroepithelial hair cells in the form of a small mound. The tops of the hair cells are embedded in a gelatinous material, the cupula. The motion of the cupula caused by movement of the endolymph stimulates the hair cells of the ampulla and brings about the perception of motion. All the semicircular canals communicate with the utricle, while the saccule communicates with the membranous cochlea.

Both utricle and saccule give off ducts, which unite to form the ductus endolymphaticus, which passes through a fissure in the temporal bone and emerges in the posterior cranial fossa on the posterior surface of the bone and forms the saccus endolymphaticus, located extradurally. It is thought that equal pressure on both sides of the saccus is necessary for undisturbed equilibrium.

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Labyrinthine Tests

With a 512 cycle per second tuning fork, ice water, and a 2 cc. syringe, the physician can test the vestibular and cochlear labyrinth reliably and rapidly. The following procedures are not difficult, and if done only a few times, will seem quite simple.

Caloric Test: Fill the ear canal with ice water and let it drain out after 10 seconds. Wait one minute and tilt the head back 60 degrees. The patient watches the examiner's finger, which is placed to the side opposite the ear being tested, and the duration of nystagmus is timed. After a few minutes, the opposite ear may be tested. Any great difference between the two ears is significant. If vestibular disease is present, the involved labyrinth will be hypoactive, contrary to popular belief.

Before doing the caloric test, one should observe the patient for positional nystagmus. This is nystagmus which originates with changes in the position of the head and, if present, is pathological.

Weber Test: This is a reliable means of determining whether a unilateral hearing loss is conductive (otitis media, otosclerosis, etc.) or a disorder in the cochlear or neural mechanism. A 256 or 512 cycle per second tuning fork is activated and placed on the forehead or vertex of the skull. In nerve lesions, the sound is heard in the good ear. In conduction deafness, it is heard in the bad ear. More sophisticated tests can further localize the lesion and can be performed by an otologist.

Cause of Vertigo

Any disorder affecting the vestibular system, from the end-organ to the vestibular nuclei in the brain

stem, can cause vertigo. The system is divided into three parts, end-organ (peripheral), vestibular nerve (intermediate), and central vestibular pathways (central). The causes are listed in Table 1. The striking feature is that vertigo can have so many causes.

Diagnosis of Vertigo

Central: In general, central vertigo is the most difficult to diagnose. The history is usually bizarre; the caloric test and hearing may be normal. However, positional nystagmus, when found, is significant. Nylen,¹ in 673 cases of brain tumor, found positional nystagmus in 90 per cent of posterior fossa tumors and 26 per cent of supratentorial tumors. Vascular insufficiency (vertebral-basilar artery); toxic drugs, such as alcohol, barbiturates, and phenothiazines; multiple sclerosis; and trauma can also cause central vertigo. In the everyday practice of otology, the most common cause of central vertigo (and intermediate and peripheral) is benign paroxysmal postural vertigo (BPPV). Another name given is "epidemic vertigo." In this condition, the key word is "bed." The patient complains of severe vertigo when arising and retiring, and when turning over in bed, he will be awakened from a sound sleep if he turns to a given side. In the first 48 hours, positional nystagmus is present in most patients. The caloric test and the hearing are normal.

According to Barber,² only 10 per cent of central vertigo is psychogenic. In the writer's experience, an interesting positive finding in the patient with psychogenic vertigo is the subjective response to the caloric test. He will complain of extreme vertigo immediately after the instillation of the ice water (the normal onset being 30 seconds), grasp the examiner's hand, arm, or leg, and threaten to vomit. He will open his eyes and follow the finger only after the greatest persuasion. Objectively, the duration of nystagmus is normal, as is the hearing. The patient with psychogenic vertigo does not awaken out of a sound sleep when turning over, while the patient with benign postural vertigo does.

Intermediate (Vestibular Nerve): Few conditions affect the vestibular nerve, but they are important. Vestibular neuronitis is a condition usually related to a severe viral infection. It causes vertigo, which lingers for many months. The hearing is normal but the caloric reaction is markedly depressed or absent.

Acoustic neurinoma is supposedly a rare condition, but in a study of 250 unselected temporal bones, Hardy and Crowe³ found six small neurinomas. This is an incidence of 2.4 per cent. The presenting symptoms late in the course of the disease are ataxia and dizziness, unilateral deafness, tinnitus, trigeminal hypesthesia, and facial weakness or paralysis. Clinical findings are absent caloric reaction, unilateral neurosensory deafness, V and VII nerve signs, and cerebellar signs. Roentgenograms show enlargement of

TABLE 1. *Origin of Vertigo*

Central	Intermediate Vestibular Nerve	Peripheral (End-organ)
1. Vascular (vertebral-basilar) insufficiency	1. Vestibular neuronitis	1. Meniere's disease
2. Tumor	2. Acoustic neuroma	2. Labyrinthitis
3. Epilepsy		3. Vascular, inner ear
4. Head injury		4. Head injury with temporal bone fracture
5. Infection		5. Ototoxic drugs
6. Epidemic vertigo (benign paroxysmal postural vertigo)		
7. Multiple sclerosis		
8. Psychogenic		

the internal auditory canal, with erosion of the petrous tip. Spinal fluid protein is elevated.

Early diagnosis of acoustic neurinoma is difficult and, until recently, infrequent. In William House's series,⁴ all had a unilateral sensory neural deafness, 82 per cent had vestibular symptoms (transient postural vertigo was considered positive), 96 per cent had depressed or absent caloric reaction in the involved ear, and 25 per cent had normal spinal fluid protein. Given a patient with normal x-rays, abnormal audiogram, and depressed caloric reaction, House considers the posterior fossa myelogram the single most important diagnostic test. Non-filling of the internal auditory canal with iophendylate is considered diagnostic of acoustic neurinoma.

Today, a patient with a unilateral hearing loss must be evaluated much more thoroughly than in the past. Vestibular symptoms early in the course of the disease may be absent. It is clear, then, that a caloric test should be performed on all suspicious cases.

End-Organ: As can be seen in Table 1, many conditions can affect the end-organ. One of the most distressing is Meniere's disease. This consists of the triad of periodic unilateral deafness, tinnitus, and vertigo. Early in the course of the disease, the episodes are infrequent and the hearing fluctuates. Later, the deafness is permanent and vertigo in some degree is always present. The tinnitus is unique, in that it changes pitch frequently. Sections of temporal bones at autopsy reveal hydrops of the membranous labyrinth.

Labyrinthitis can be the result of direct bacterial or viral invasion of the inner ear from otitis media or meningitis. In these cases there are usually outward signs of infection. Labyrinthitis can also be caused by erosion of the osseous labyrinth by a cholesteatoma, which is a skin-lined cyst. In this situation, either a perforation of the pars flaccida or a marginal perforation of the pars tensa is present. The perforation may be difficult to visualize, especially one involving the pars flaccida, and discharge may be scant.

Head injuries, with or without temporal bone fractures, can cause vertigo. In cases with fracture, the

hearing and caloric responses are depressed. In cases without fracture, the cochlear and vestibular studies may be normal, and the symptoms disappear in three or four weeks. Malingering can be suspected in the patient who has normal x-rays and other tests, if his vertigo lasts longer than one month.²

Vascular problems as a cause of vertigo can be suspected in elderly patients. Typically, the episode is transitory and is precipitated by arising from a sitting position, or by turning the head and thus occluding the vertebral artery. Hemorrhage into the labyrinth will cause sudden vertigo and deafness. Recovery of equilibrium requires three to four weeks, but the deafness is permanent.

Now that the medical profession is acutely aware of ototoxicity of drugs, end-organ disease due to prolonged parenteral use of streptomycin, dihydrostreptomycin, neomycin, and kanamycin is disappearing. Quinine is ototoxic, but its use is negligible. Large doses of salicylates can cause tinnitus and hearing loss, but this is relieved by withdrawal from the drug.

Treatment of Vertigo

Central: In general, the underlying disease should be treated. If the cause is infection, treatment should be focused on that. In vascular vertigo, nicotinic acid taken in doses which cause flushing is bene-

ficial to many. Benign postural vertigo is self-limited, and although many drugs have been tried, it is the author's experience that rest and reassurance are the best medicine. In psychogenic vertigo, frankness in explaining the condition is a great help.

Intermediate: In the treatment of vestibular neuritis, labyrinthine depressants, such as meclizine, are of limited value but do help some patients. Adequate rest and avoidance of stimulants, such as smoking and coffee, are important.

The treatment of acoustic neurinoma has undergone change in recent years. Since diagnosis usually has been made late in the disease, the operative mortality has been high. The California Tumor Registry shows that from 1942 to 1962, 36.5 per cent of the patients operated upon by the classical suboccipital route died within one month of surgery. In addition to this, total removal is a great problem. Pool,⁵ in his series, operated on 135 patients a total of 162 times. Total removal was accomplished 39 times, or 24.1 per cent.

House, in his monograph, "Transtemporal Bone Microsurgical Removal of Acoustic Neuromas,"⁶ has shown that if the diagnosis can be made early, the removal can be accomplished via the translabyrinthine route, with total removal and fewer deaths and lower morbidity. In his series of 51 cases, his operative

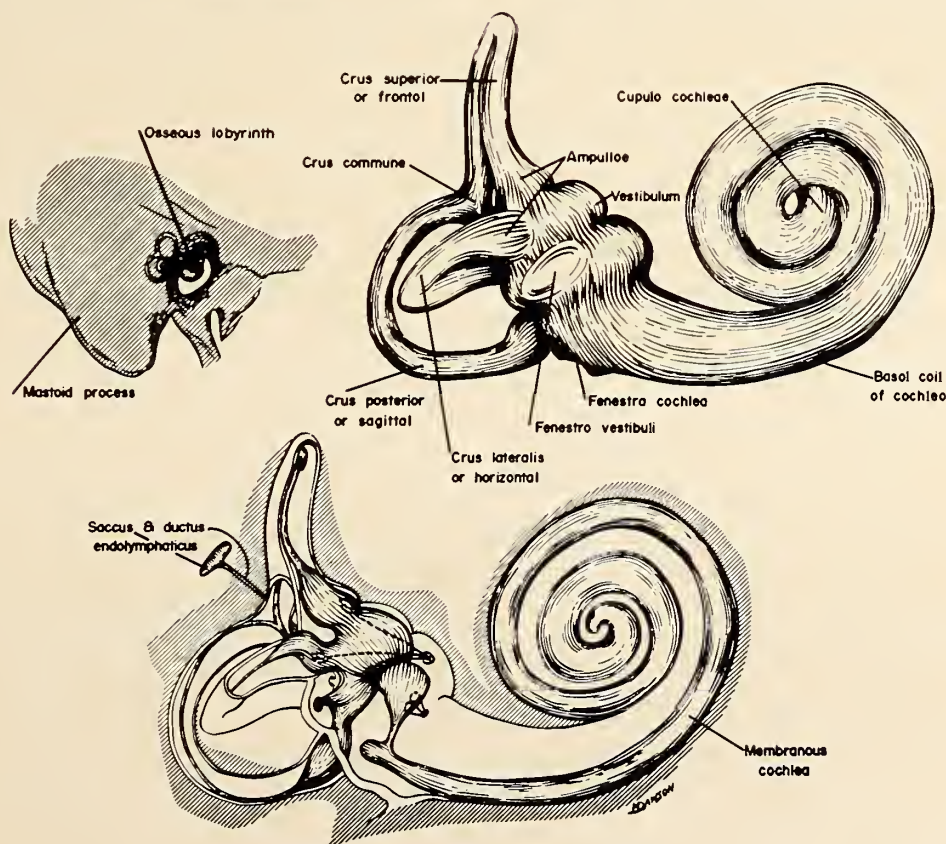


FIG. 1. Illustration of anatomy of the labyrinth and its relationship to the temporal bone.

mortality was 5.4 per cent. If we are to diagnose this entity early, we must be very suspicious of every instance of unilateral nerve deafness.

Peripheral: It is difficult to evaluate any treatment of Meniere's disease because spontaneous remissions occur. The acute phase is best treated by bed rest and sedation. Motion sickness drugs may help. After the patient has had several severe episodes, he becomes fearful of the next attack. In the author's experience, this can be as great a problem as the acute attack. Encouragement and reassurance are necessary and must be reinforced at times. If the patient suffers continually from Meniere's disease and is unable to work, the treatment of choice is the endolymphatic subarachnoid shunt operation.⁷ In the author's experience, 75 per cent of the patients are relieved of their vertigo. An interesting bonus is that in 10 per cent of the patients the hearing is improved.

Labyrinthitis should be treated according to its cause. In meningitis and otitis media, specific antibiotics should be used. If a cholesteatoma is present, it should be removed. If the labyrinthitis is due to inner ear hemorrhage, a short period of bed rest is the best treatment.

Head injuries with temporal bone fractures should be under the care of a neurosurgeon. At the present time, there is no surgical or medical remedy for the damage done to the labyrinth. If the vertigo persists and is debilitating, a labyrinthectomy should be done.

Conclusions

1. Vertigo is not only due to disorders in the end-organ but may be intermediate or central in origin. The symptoms may vary from occasional unsteadiness to true spinning.

2. While some types of vertigo are benign, others are a sign of serious disease. Cochlear and vestibular tests are necessary to differentiate between the two.

3. Unilateral sensorineural hearing loss, with or without dizziness, is an important symptom and deserves thorough investigation. The patient with this symptom should have thorough auditory testing, a caloric test, and roentgenograms of the internal auditory canal. If suspicion persists, the cerebrospinal fluid should be examined for increased protein and a posterior fossa myelogram performed to rule out the presence of an acoustic neurinoma.

4. The endolymphatic subarachnoid shunt has proved of value in the treatment of intractable Meniere's disease.

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BIOTELEMETRY will start to invade medicine in force by 1970. Patient care will ultimately be revolutionized by the concepts which will be experimentally under way at that time. Low-cost miniature telemeters will be used in hospitals to monitor patients during and after surgery; a technic for dissolving the implant package into the body waste system after a reasonable time will be developed.

Outpatient treatment will be the order of the day; ambulatory and bedridden people requiring medical supervision will be monitored by telemetry at home or on their jobs. Two-way telecommunication with prosthetic devices and artificial organs will be perfected; conscious control by a paralyzed person, for example, will be exerted via implant trans-receivers on powering devices to move atrophied arms and limbs. The concept of automatic self-regulated therapy by means of chemical restorative implants (that is, insulin, adrenalin, and so on) will be seriously under study. The dawn of a new, quantitative era in psychotherapy, through dynamic telemetered measurements of evoked response and behavior, will begin. —Lloyd E. Slater, Associate Director of Research Administration, Case Institute of Technology, Cleveland, Ohio: *New York State Journal of Medicine*, 65:2893-2901, December 1, 1965.

The Schiötz Tonometer at Rest

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TONOMETRY has become a welcome addition to the procedure of a physical examination. The examining physician must be assured that the instrument is in good working order. Instructions in the maintenance of a tonometer during the interval when it is not being used for recording ocular tension, seems to be absent from the literature. The accumulation of dried tears along the shaft, accumulation of debris along the moving parts or inadvertent careless handling may modify the accuracy of the instrument. Nurses, residents, interns, and students who handle the instrument may be benefited by a review of the author's method which assures a smoothly functioning instrument.

Immediate Post-Use Care

The care of the instrument begins after a recording is made. The instrument should be held across the fingers with the footplate extending beyond the little finger, the thumb resting firmly on the weight, the plunger at its nethermost position. With a piece of facial tissue or equivalent, all of the exposed piston and the footplate are dried to remove tears or secretion adhering to the instrument. The thumbnail is used to push the tissue around the plunger. The footplate should be flamed for 45 seconds as described by Rosenbaum.¹ A half-inch high alcohol flame fueled by commercial denatured alcohol in a conventional alcohol lamp is appropriate for this purpose. The tonometer so flamed will be safely cooled and ready for reuse in five minutes. The average Schiötz tonometer so heated will not be damaged as proven by Rosenbaum.²

Method of Storage

If the instrument is kept in the office or clinic, it is not returned to its case. The tonometer is suspended by the lower part of its dial on two parallel pins placed horizontally about 20 mm. apart. In this position the instrument hangs with the pointer past the "20" mark and the plunger is in its nethermost position. The pins are fastened to the wall of a cabinet in the author's office. In this suspended position, there is no contact between the footplate and the wall.

Because the footplate and plunger are sterile when the instrument has been properly flamed, any organ-

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ism reaching the footplate after cooling could come only from the atmosphere. Air-borne contaminating organism would be the same that might enter the open eye from the atmosphere. The tear film of the intact eye can very well neutralize this type of contaminant as proven by Meyer et al.³

If the tonometer is to be kept in its case ready for use outside the office, the instrument is flamed in the usual manner. To assure sterility of the footplate, an individually wrapped sterile 2 by 2 pad or eye dressing is packed with the tonometer. One end of the sterile envelope is torn away and the flamed end of the instrument is inserted into the envelope. The sterile dressing is retained in the envelope and is available as a wipe. After use, the footplate is wiped and returned to the now empty envelope. The empty envelope is a reminder that the instrument has not been flamed after its most recent use. With this procedure, the case is less likely to have contaminating organisms introduced therein.

The cleanliness of the case is of some importance. The lining may be cleaned with the small tip of a vacuum cleaner. Another, more efficient method is to apply adhesive or pressure-sensitive tape to the dusty lining. The dust will adhere to the adhesive which, when pulled away, leaves a bright clean lining.

Cleaning Procedure

The process of cleaning a tonometer should follow a definite pattern. At least once a week, oftener if so required, polishing is performed with silicone-treated paper. The paper used is the type that is available in match-book size which is sold for cleaning spectacles. The plunger is removed from its cylinder by unscrewing or sliding the weight off. This permits the plunger to drop out. It is then polished with the silicone paper. A piece of the paper is wrapped tightly around an applicator stick and the

cylinder is then polished with a to-and-fro and rotary motion of the stick.

Water may be used to wash away any accumulation of dried tears in the form of salt crystallized on the wall of the piston. For this procedure, the cylinder is wiped with a very thin layer of moist cotton wound on the applicator stick. The ordinary cotton wound applicator is too thick and may injure the instrument. Upon completion of the cleansing procedure, care should be taken that no paper or cotton is retained in the cylinder. The assembled instrument is then flamed and placed in position ready for use.

At infrequent intervals it may be noted that the cylinder of the handle is not operating smoothly. In this event, it will be necessary to remove the handle for cleaning. To assure accurate reassembly, it is wise to place an identifying scratch mark on the upper surface of the footplate directly opposite the small bolt that keeps the cylinder in place. The bolt is then loosened and the cylinder unscrewed. The outer surface of the cylinder is cleaned and polished with silicone paper as well as the inner surface of the handle cylinder. These surfaces should then move with minimum friction.

In reassembling the instrument, the cylinder should

be screwed in place with the scratch mark on the footplate opposite the loosened bolt. If the instrument needle rested at the "zero" mark on the test plate before disassembling, the instrument should again record "zero" on the test plate. If the tube is turned too far to the right (too tight), the needle will drop below zero when tested on the footplate. The converse is of course true if the cylinder is too loose.

None of the preceding should be construed as a substitute for sending the instrument to the testing station at regular intervals as the authorities advise. In the author's experience, these procedures have assured prolonged, trouble-free, accurate recordings with a "safe" instrument.

Summary

The author's procedure for keeping a tonometer clean, sterile, and working smoothly is described.

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CYTOTOXIC DRUGS and other agents can be of very great benefit to patients with malignant disease, but they can be dangerous if used incorrectly. They may produce serious side-effects, they may prevent adequate treatment by other methods, and, when ambiguous results are published, they encourage others to adopt the same viewpoint. Of course, there is nothing to stop any registered medical practitioner from using these potentially dangerous agents, without any specialized knowledge of cancer or any previous training in their use.

When cytotoxic drugs are misused, it is probably because of the following chain of events: (1) The doctor, perhaps not fully aware of the natural history of the disease in his patient, feels excessively pessimistic about the chance of cure or palliation by conventional methods. (2) The doctor is human and wishes to help the patient. (3) Chemotherapy is a harmless word; obviously, if a doctor is qualified to use penicillin, he is qualified to use a cancer chemotherapy agent. (4) The patient is human and if he knows the nature of his illness or has symptoms, he naturally wants something done. (5) Relatives are also human and want action — preferably with the newest agent. And so, another course of a cytotoxic agent is given. Under these circumstances, it is difficult to judge who receives the greatest palliation — the patient, his relatives, or the doctor. — Dr. A. M. Jelliffe, London: *Proceedings of the Royal Society of Medicine*, 59:1261-1268, December 1966.

Infectious Mononucleosis Complicated By Hemolytic Anemia

Report of a Case

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INFECTIOUS mononucleosis is ordinarily a benign self-limiting disease of gradual and uneventful recovery.¹ There are, however, several serious life-threatening situations which can arise and one of these is acute hemolytic anemia. Thus far, approximately 30 cases^{2,3} of this important complication have been reported, and the treatment has varied from conservative management to splenectomy. The following case is presented to demonstrate the rapid and beneficial response of the anemia to steroids.

Case Report

A 17 year old white female student was in good health until 12 days before admission to the hospital when she experienced generalized myalgia, malaise and anorexia. Nine days prior to admission she developed a low grade fever along with a sore throat. Three days before admission she noted that her urine was dark and because this persisted she sought medical aid and was promptly admitted to the hospital.

The past medical history was not remarkable. There had been no previous drug administration, injections, transfusions or exposure to chemicals.

Physical examination revealed a deeply jaundiced, white female who appeared acutely ill. Temperature was 101°F (38.3°C) by mouth; the pulse rate was 92 beats per minute and the blood pressure was 110/70 mm Hg. The scleras were deep yellow and the conjunctivas were slightly injected. The palatine tonsils were markedly enlarged and inflamed. No petechiae were seen. There were many discrete tender lymph nodes palpable in both posterior cervical and axillary areas. The spleen was palpable 2 cm. below the left costal margin and slightly tender. The liver was felt 5 cm. below the left costal margin and was also tender. The remainder of the physical examination was within normal limits.

The laboratory examination at the time of admission revealed a hemoglobin of 11.2 Gm/100 ml., hematocrit 32 per cent, white blood cell count 9,475 per cu. mm. with a differential of 52 per cent lymphocytes (13 atypical), 34 per cent segmented, and 1 per cent band neutrophils, and 13 per cent monocytes. The urine was positive for protein and bilirubin. The heterophil agglutination titer was 1:3584 unabsorbed, 1:896 with guinea pig absorption and negative with beef cell. Serum chemistries were as follows: total bilirubin 20.75 mg/100 ml. with direct reacting of 11.7 Gm/100 ml., glutamic oxalacetic transaminase 148 units, glutamic pyruvic transaminase 280 units, lactic dehydrogenase 1700 units, alkaline phosphatase 450 (sigma) units, total protein 7.0 Gm/100 ml. with albumin

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3.6 Gm/100 ml., and globulin 3.6 Gm/100 ml. and cephalin flocculation 4 plus. Lupus erythematosus clot preparations, throat culture, serum cholesterol, thymol turbidity, Pangborn serology, chest x-ray, electrocardiogram and multiple blood cultures were all within normal limits. Multiple stools for occult blood were not remarkable.

During the first five days of hospitalization the patient's course was characterized by a high fever up to 103.2°F (39.5°C), generalized weakness and an exquisitely painful throat. The hemoglobin and hematocrit gradually fell to 6.3 Gm/100 ml. and 19 per cent respectively, on the sixth hospital day. At that time the platelet count was 182,500 and the white blood cell count was 9,700 per cu. mm. with a 61 per cent lymphocytosis, of which 25 per cent were atypical. The reticulocyte count was 4.2 per cent. The indirect Coombs' test was positive. The direct Coombs and cold agglutinins were negative. The heterophil agglutination had risen one dilution to a titer of 1:1792 after guinea pig absorption. In spite of a continual drop in the hemoglobin, the bilirubin fell to a total of 11.0 mg/100 ml. and remained at approximately that level. A diagnosis of infectious mononucleosis with hemolytic anemia and hepatitis was made.

On the seventh hospital day, in an attempt to suppress the apparent hemolysis, prednisone in a dose of 60 mg. daily was instituted. Thereafter, improvement was rapid. Within four days the fever subsided, the sore throat disappeared, the palatine tonsils shrank, the lymph nodes became less tender and the liver and spleen both decreased in size. The hemoglobin and hematocrit values showed a progressive rise, along with a decline in both the reticulocytes and serum bilirubin. Two weeks after the initiation of steroids, the hemoglobin was 10 Gm/100 ml. and the serum bilirubin was normal. One month later, the heterophil, peripheral blood count, smear and cephalin flocculation were normal.

Discussion

Until the etiology of infectious mononucleosis is determined, the cause of the hemolytic anemia remains purely speculative. Thus far, three mechanisms have been advanced to explain this unusual complication.

In 1952, Moolten and Clark^{4,5} reported the isola-

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tion of New Castle disease virus from the blood of three patients with hemolytic anemia. They suggested that the virus becomes firmly attached to the red blood cell and alters its antigenic structure with the production of hemagglutination, and occasionally hemolysis. The possibility then exists that the antibody responsible for the positive Coombs' test in these patients was an antiviral antibody, rather than an autoantibody. It is generally accepted that infectious mononucleosis is due to a virus as yet unidentified. It is, therefore, possible that this unidentified virus causes hemolysis and a positive Coombs' test by direct absorption to the red blood cell. However, it seems very likely that if the infectious mononucleosis virus had this property of direct absorption and hemagglutination, then hemolytic anemia would be much more prevalent.

The splenic enlargement in infectious mononucleosis has been well established.¹ Because of this and the occasional case of idiopathic thrombocytopenic purpura during the course of the disease, secondary hypersplenism has been advanced as the cause of the hemolytic anemia.⁶ The occasional pancytopenia has likewise added evidence for this mechanism. Indeed, several cases⁷ have shown prompt recovery after splenectomy. In these cases, the Coombs' test was either negative, or not determined.

Finally, positive tests for warm, cold and Coombs' antibodies have led many to believe that the hemolytic anemia is due to an auto-immune process. It has been shown that 8 per cent of the cases of infectious mononucleosis develop the rare type specific Anti-i cold antibody.⁸ This antibody has even been demonstrated in one of the patients with hemolytic anemia.⁸ Certainly in those patients with a positive Coombs' test, the response to steroids would be consistent with an auto-immune hemolytic anemia. In the case presented, such a process was thought to be operating and the patient was started on treatment

with prednisone and continued on this medication in decreasing doses for approximately three weeks. The reversal of the patient's illness in general, and hemolysis in particular, was spectacular. A review of the six other cases^{2,3,6,9-11} in which steroids have been used, suggests similar results. It seems logical, therefore, that steroids are the treatment of choice in any patient with infectious mononucleosis, who develops a Coombs-positive hemolytic anemia.

Summary

A case of infectious mononucleosis complicated by severe progressive, Coombs-positive, hemolytic anemia has been presented. The short-term use of steroids was associated with a rapid improvement of the hemolytic process. Some of the possible etiologic mechanisms of this complication were discussed.

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THE FOG INDEX. — Robert Gunning, author of "The Technique of Clear Writing," a good companion to Strunk's "The Elements of Style," has evolved a formula to test clarity of writing.

1. Take any block of words — not less than 100;
2. Figure the average number of words per sentence;
3. Count the number of words with three syllables or more per 100 words. Add that number to the average number of words per sentence;
4. Multiply by 0.4. This gives the fog index. Anything above 14 approaches the danger area — too hard to grasp.

We tested the above block of words and the fog index came to 8.4. — Editorial©, *New York State Journal of Medicine*, 66:3126, December 15, 1966. (Reprinted with permission of the Editor.)

A Baedeker for Fat-Controlled Diets

II. Types of Hyperlipidemia and Their Response to Diet

HELEN B. BROWN, Ph.D.,* and MARILYN FARRAND, M.S.†

IDENTIFICATION of the various kinds of hyperlipidemia is important for correct treatment. Five types of familial hyperlipidemia may be characterized by determining the various lipoprotein fractions by paper electrophoresis.¹ Three types are commonly encountered² and are associated with vascular disease and formation of xanthomatous deposits. They differ in the amounts of cholesterol-rich, low density beta lipoproteins and triglyceride-rich, very low density beta lipoproteins. A simple way to describe them is by comparing the relative amounts of serum cholesterol and triglycerides in each type (Fig. 2). In *hypercholesterolemia*, as the name implies, cholesterol levels are abnormally high; triglycerides are relatively normal. *Hyperglyceridemia* is characterized by a disproportionately high triglyceride level; cholesterol may or may not be elevated. *Mixed hyperlipemia* has both high serum cholesterol and triglyceride levels but in normal proportion to each other.

Choice of Diet—Low-Fat or Vegetable-Oil?

In hypercholesterolemia, serum cholesterol reduction occurs equally well with either the low-fat diet or the vegetable-oil food pattern; the triglyceride level is only slightly affected. Weight, food preferences and living habits influence the choice of diet. On the other hand, the vegetable-oil food pattern is preferable for most cases of hyperglyceridemia and mixed hyperlipemia, because it maintains lower and less variable serum lipid levels than the low-fat (high-carbohydrate) diet in these types.³ The proportionately high carbohydrate content of the low-fat diet further elevates triglyceride levels in these patients, who are described as carbohydrate sensitive. In

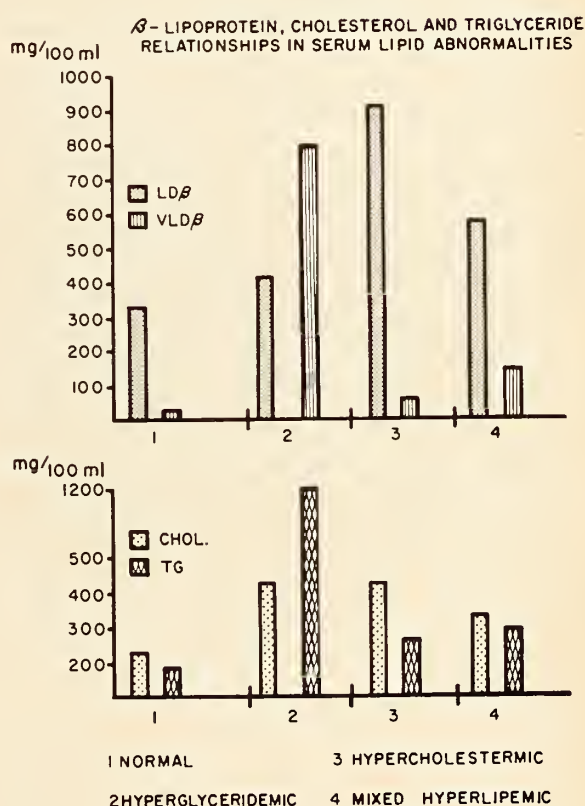


FIG. 2. Graph showing beta lipoproteins, cholesterol and triglyceride relationships in serum lipid abnormalities.

LDβ — low density beta lipoproteins
VLDβ — very low density beta lipoproteins
CHOL — cholesterol
TG — triglyceride

these patients a family history of diabetes is often present, and a glucose tolerance test may be abnormal.¹

The low-fat diet is best for those persons with a strong preference for low-fat foods. It is also easier to follow in restaurants. Because of its low caloric content, the low-fat diet may be used for weight reduction. Men usually lose weight with this diet without rigid calorie restriction; small women need

The Heart Page is a periodic feature of *The Journal* containing brief, practical comments on subjects of immediate importance to practicing physicians. The comments are solicited by the Professional Education Committee of the Ohio State Heart Association.—Ed.

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calorie control because of their low caloric requirements. During weight loss, both serum cholesterol and triglycerides are reduced, regardless of the type of hyperlipidemia.

The vegetable-oil food pattern is suitable for all three types of hyperlipidemia and is mandatory for the person who is extremely sensitive to dietary carbohydrate. It is less restrictive and more palatable than the low-fat diet and is adaptable to ordinary living conditions. The vegetable-oil food pattern is satisfactory to use over many years.

Response to Diet. Two to three weeks are required for a serum cholesterol decrease which is maintained as long as the diet is followed, while only a few days are required for serum triglyceride change. In persons with normal lipids, serum cholesterol levels are reduced about 15 per cent with either diet; serum triglycerides remain below 150 mg per 100 ml. Triglycerides are not altered with the vegetable-oil food pattern, but may be increased about 25 per cent with the low-fat diet.

In the majority of hyperlipidemic persons, both serum cholesterol and triglyceride levels are reduced and maintained at lower levels with adequate dietary treatment. In mixed hyperlipemia, both cholesterol and triglycerides are reduced satisfactorily. Approximately normal levels are attained and maintained easily over a long period. This change in serum lipids in mixed hyperlipemia was observed in a man whose serum cholesterol level was reduced from 375 mg per 100 ml to an average of 270 mg (260 - 290 mg range) with the vegetable-oil diet and maintained at the lower levels for eight years. Triglyceride levels were reduced from 360 mg to an average of 135 mg per 100 ml (90 - 150 mg range).

In hyperglyceridemia, there is a reduction in both lipid levels. Serum cholesterol usually drops below 300 mg per 100 ml but triglycerides tend to remain above 200 mg. Serum lipid levels are more variable than in the other types of hyperlipidemia, and reflect daily changes in fat and carbohydrate intake. For

example, a man whose serum cholesterol was reduced from a level of 490 mg per 100 ml to 295 mg (250 - 350 mg range) with the low-fat diet showed a level of 260 mg and a range of 230 - 290 mg with the vegetable-oil food pattern. His serum triglycerides were reduced from 800 mg per 100 ml to 500 mg with the low-fat diet, and to 290 mg (150 - 350 mg range) with the vegetable-oil food pattern and were maintained at lower levels for eight years.

Hypercholesteremia is more resistant than the other hyperlipidemias to dietary treatment. In some patients serum lipids may decrease very little or not at all. In the majority of patients, however, serum cholesterol levels are reduced about 25 per cent, yet they remain above 300 mg per 100 ml. This type of response occurred in a man whose serum cholesterol level was reduced from 450 mg per 100 ml to 335 mg with the vegetable-oil diet. It has remained about this level for the past seven years. Triglycerides were relatively unaffected.

A few hypercholesteremic patients may have a gradual rise in serum cholesterol levels while on the diet.³ An example of this is a man whose serum cholesterol level was initially reduced with the vegetable-oil food pattern from 400 mg per 100 ml to 300 mg. During the next seven months of dietary treatment it gradually rose to 385 mg. When he resumed his usual pattern of eating, his cholesterol increased to 500 mg, 100 mg above the original control level.

The next Heart Page will discuss fat composition and nutritive adequacy of fat-controlled diets.

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CHANGES IN BLOOD LIPID LEVELS following substitution of eggs for cereal in the breakfast menu, and vice versa, were studied in 20 men living in a Veterans Administration Domiciliary Unit. The composition of the remaining meals was not modified. Subjects who received the cereal breakfast for six weeks and were then switched to the egg breakfast showed a significant 11 per cent increase in plasma cholesterol and temporary reduction in plasma triglycerides. The switch-over from the egg breakfast to the cereal breakfast was followed by a temporary reduction in plasma cholesterol and an increase in triglycerides. — Joseph J. Barboriak, Ross C. Kory, et al.: *Journal of The American Dietetic Association*, 49:204-207, September 1966.

A Clinicopathological Conference

From The Ohio State University Hospital, Columbus, Ohio

Edited Under the Auspices of the Ohio Society of Pathologists

J. B. McMILLAN, M. B., Ch. B., *President*

PRESENTATION OF CASE

A SIXTY-THREE year old Negro male porter was admitted to University Hospital because of increasing obtundation. He had apparently been in good health when 24 hours prior to admission he gradually became mentally obtunded, dysarthric, and unable to get out of bed. He fell from his bed, injured the right side of his forehead, and was brought to the University Hospital emergency room. There was no history of headaches, syncopal episodes, dizziness, weakness, or episodes of confusion prior to the onset of the present illness.

The past history revealed that a partial gastrectomy had been performed for peptic ulcer disease 15 years prior to this admission. The patient had been a heavy smoker all his life and had ingested considerable amounts of ethanol. He had a history of hypertension for the past seven years, during which time he had been seen in the Outpatient Clinic. At an outpatient visit six years prior to admission he was found to have a hemoglobin of 18.4 Gm. and a hematocrit of 66.5 per cent.

Physical Examination

The patient was well developed, obtunded, oriented only to name, and in no apparent acute distress. The blood pressure was 230/120, the pulse rate 84/min., the respiratory rate 20/min., and the temperature 99.8°F. Examination of the skin revealed no petechiae or ecchymoses. A 6 by 4 cm. hematoma was noted in the right frontal area. The pupils were equal and reacted to light. The funduscopic examination revealed sharply outlined discs and arteriolar narrowing. No hemorrhages or exudates were noted. The tongue was in the midline, and the gag reflex was present. The carotid pulsations were full, equal, and without bruit. There was no venous distention. The thyroid was not enlarged. There was no cervical lymph node enlargement. The lungs were clear to percussion and auscultation. The point of maximal impulse of the heart was 2 cm. outside the mid-clavicular line in the sixth left interspace, with a left ventricular heave. The heart had a regular sinus rhythm with frequent premature ventricular contrac-

Presented by

- Robert L. Wall, M.D., Columbus, and
 - Francis E. Cuppage, M.D., Columbus;
- Edited by Dr. Cuppage.

tions. No murmurs were heard. An atrial gallop was present. The abdomen was soft and nontender. The liver, spleen, and kidneys were not palpable. No abdominal masses were felt. No edema or cyanosis was present in the extremities. The peripheral pulses were full and equal bilaterally.

The neurological examination revealed the patient to be obtunded and oriented to person only. He was able to respond to verbal commands. The cranial nerves were intact. There was a slight weakness of the extremities. There were Babinski and Hoffman signs and unsustained clonus on the right. The deep tendon reflexes were 3 plus on the right and 2 plus on the left.

Laboratory Data

Laboratory studies on admission disclosed the following values: hemoglobin 20 Gm./100 cc.; hematocrit 69 per cent; white blood cell count (WBC) 23,000/cu.mm. with 91 per cent neutrophils; platelets 430,000/cu.mm.; blood sugar 112 mg., blood urea nitrogen (BUN) 15 mg., creatinine 1.5 mg./100 cc.; CO₂ combining power 29 mEq., sodium 138 mEq., potassium 4.8 mEq., chloride 97 mEq./liter; alkaline phosphatase 10.5 units; uric acid 7.7 mg./100 cc.; calcium 4.6 mEq./liter. The urine contained 640 mg. of protein per 100 cc., and the centrifuged sediment contained 10-15 WBC/h.p.f. Culture of the admission urine produced no growth; a repeat urine culture yielded a heavy growth of *Enterobacillus*. The VDRL test was nonreactive. Blood volume studies revealed: red blood cell volume 1,950 cc. (theoretical 1,400); plasma volume 2,775 cc. (theoretical 1,850); total blood volume 4,725 (theoretical 3,250); hematocrit 45 per cent; mean body plasmocrit 58.6 per cent. Blood gas studies revealed: oxygen satura-

tion 88.6 vol. per cent, $p\text{CO}_2$ 32.3 vol. per cent; pH 7.51.

Left ventricular predominance of the heart and old granulomatous disease of the hilus of the lung were observed on chest x-ray. No acute pulmonary process was noted. X-ray examination of the skull showed a probable fracture of a right facial bone at the level of the zygoma.

The electrocardiogram revealed premature ventricular contractions, nonspecific ST and T wave changes, and probable left ventricular hypertrophy.

Hospital Course

A lumbar puncture was performed following the patient's admission to the hospital and disclosed the following: a hazy, red, xanthochromic fluid; an opening pressure of 340 mm. of water; 900,000 RBCs, 1,000 WBCs/cu.mm.; protein 340 mg., sugar 76 mg./100 cc. (simultaneous blood sugar 112 mg.); no bacteria were identified or grown on culture.

During the first several days in the hospital the patient's sensorium vacillated with periods of lethargy and unresponsiveness and periods in which he was fairly alert.

Initially, the patient was started on intravenous fluids and was phlebotomized twice for a total of 1,000 cc. A neurology consultant noted, in addition to the previously described neurological findings, a right homonymous hemianopsia, a depressed right corneal reflex, and right facial weakness.

On the seventh hospital day the patient had fever and treatment was started on antibiotics because of the positive urine culture. Later in the hospital course his mental status improved and tube feedings were started. A spinal tap repeated on the eighth hospital day revealed a slightly xanthochromic fluid containing 4 RBCs and 110 mg. of protein. A Kinsman laboratory blood count done on the 16th hospital day revealed 19,000 WBCs, 7.11 mil. RBCs; hemoglobin 16.4 Gm.; platelets 1.6 mil.

On the 17th hospital day, while sitting in a chair, the patient suddenly became unresponsive with accompanying hypotension and apnea. He was intubated, put on a respirator, and the blood pressure was maintained by pressors. A spinal tap showed slightly xanthochromic fluid. The patient continued to be unresponsive on the respirator and died on the 19th hospital day.

CLINICAL DISCUSSION

DR. FRIEDMAN: I think we have an interesting patient with many problems. Dr. Wall will discuss the clinical aspects of the case.

DR. WALL: This elderly man apparently had a great number of difficulties, many of which were never explored in depth while he was in the hospital. I think almost everyone would agree that he did have polycythemia. There is some debate on how much erythrocytosis is necessary to make a diagnosis of polycythemia. Polycythemia is strongly suggested

with a hematocrit of 66 and a hemoglobin of 18.5 Gm. even six years preceding the final episode. The actual history antedating his hospitalization was of about 24 hours' duration with the slow onset of confused mental state, some difficulty in speech which was preceded by this mental confusion, followed by a fall out of bed. Apparently his confusion and dysarthria preceded the actual fall out of bed.

The patient had a valid history of peptic ulcer requiring partial gastrectomy 15 years previously. We have no idea of how his ulcer was managed or whether he had any subsequent symptoms related to it. Peptic ulcer has a much higher incidence in polycythemia, especially in polycythemia rubra vera, but also in polycythemia secondary to pulmonary disease. Very frequently the peptic ulcer disease is difficult to control until such a time as the polycythemia is managed properly. In addition, he was a very heavy smoker and ingested considerable alcohol, both of which could contribute to peptic ulcer disease.

The patient was admitted with a persistence of his hypertension of 230/120. He did not show any bleeding episodes except the hematoma that was related to the fall out of bed. His pupils were equal and reacted to light, and the fundoscopic examination was fairly normal except for some arteriolar narrowing. In view of his long-standing hypertension, I think it is interesting that he had no hemorrhages, exudates, papilledema, or other significant changes. His lungs were clear to percussion and auscultation. He had an enlarged heart with a ventricular heave compatible with his long-standing hypertension. No renal masses were palpated.

The neurological examination, except for the fact that he was quite confused, was mainly right-sided with a positive Babinski and Hoffmann sign and some slight weakness and hyperreflexia on the right—suggesting an upper motor neuron lesion. I would imagine that at this time he appeared to the clinicians to have cerebral thrombosis. They were probably thinking in terms of his polycythemia relating to the thrombosis, but also were likely thinking in terms of his hypertension for possible bleeding intracranially.

Arterial O_2 Unsaturation

The polycythemia was once again confirmed during the last hospitalization by a 20 Gm. hemoglobin and 69 hematocrit, attended with a leukocytosis of 23,000 and platelets in a fairly normal range. Blood volume studies showed that his red cell mass and total blood volume were increased, again acceptable with his polycythemia. However, on doing blood gas studies, he was found to be significantly unsaturated, with only 88.6 vol. per cent of oxygen saturation of his arterial blood, which is surely below our normal set levels of 92 to 95. This suggests

the possibility that some of his polycythemia could have been mediated by some system that produced hypoxia, such as chronic pulmonary disease or a shunt system. His $p\text{CO}_2$, however, was actually decreased, and his blood pH was slightly elevated.

It is a little difficult at this time to place his arterial oxygen saturation in its proper perspective without any other description of pulmonary complaints and any other evidence of a shunt system or something else that would give us a lead to the reason for this unsaturation. I believe if you would see enough severely polycythemic people and do these studies at the time when they are not treated, you will occasionally see some people, especially if they have associated cardiac disease with congestive failure, who may have temporarily reduced saturation even as low as 86 vol. per cent. After they are better compensated cardiac-wise and polycythemic-wise, the saturations may actually improve.

His electrocardiogram showed only some findings compatible with long-standing hypertension. The urine contained a considerable amount of protein with some white cells but no red cells. It is interesting that he had this degree of proteinuria without any azotemia, as his blood urea nitrogen and creatinine were normal and his electrolytes were fairly respectable. He had a positive urine culture with a heavy growth of *Enterobacillus* that could not be ignored and may in some way relate to his proteinuria. His uric acid elevation was probably related to polycythemia. May we review his x-rays?

Radiologist's Discussion

DR. DUNBAR: His right zygoma was fractured and slightly depressed. There were no other abnormalities visualized on the skull x-rays. The chest film at the time of admission showed left ventricular enlargement and what I would consider very mild passive pulmonary congestion with slight prominence of the upper lobe vascularity, some aortic dilatation and very slight great vessel dilatation. I don't see any parenchymal lung disease. The kidneys functioned fairly well on intravenous pyelography. I don't see evidence of renal inflammatory scarring or masses which one would correlate with polycythemia.

DR. WALL: I think these films are rather reassuring in our differential diagnosis of the etiology of his polycythemia, although they do not exclude certain possibilities.

The initial lumbar puncture contained red, xanthochromic fluid which had a fair number of red cells in it, a few white cells, some increased protein, and suggested blood in his spinal fluid, with no decrease in his sugar as compared to the blood sugar. I imagine at this time it was thought that he either had a cerebral thrombosis with encephalomalacia or a cerebral hemorrhage. He improved following a phlebotomy of 2 pints and supplemental intravenous fluids. He developed a fever

and apparently at this time the urine culture findings of a heavy growth of *Enterobacillus* were observed. He was treated with some form of antibiotic medication and was started on the tube feedings.

A repeat spinal tap on the eighth day showed a marked reduction in the red cell population as compared to the initial examination with a reduction of protein. Following the phlebotomies there was some persistence of the leukocytosis and some correction of the erythrocytosis. The higher platelet count was probably due to the difference in methods used in the laboratories. Suddenly on the 17th hospital day, after improving significantly, he developed hypotension and stopped breathing. Resuscitative procedures were of no avail, and he succumbed two days later.

So we have a man who had hypertension known for seven years, polycythemia of at least six years' duration, intercurrent genitourinary infection, and probably cerebral thrombosis. We are left without an etiology for either his hypertension or his polycythemia. We have no evidence of primary pulmonary disease or any shunt mechanism as an etiology of the polycythemia. Other causes of polycythemia surely should be considered, and one that immediately suggests itself in this man is subtentorial hemangiomas. These are rare and yet they must be considered in polycythemia. A few that have been well studied have contained, when assayed, large quantities of erythropoietin. We have very little evidence to suggest this as a possibility from our neurologic observations.

Other possibilities for his polycythemia are naturally focused to his kidneys, and at least with a fairly respectable pyelogram we can suggest that he doesn't have any giant cysts that could possibly be associated with polycythemia. He does not appear to have a primary renal carcinoma or any of the other problems of the kidney that can produce polycythemia. There are people who actually have shown erythrocytosis, mild polycythemia, antecedent to the diagnosis of primary cancer of the liver, and while we know that this man had a high ethanol content for a long time, it is too tenuous to say that he had either cirrhosis or hepatic carcinoma. We are then left with the suggestion that this man had polycythemia rubra vera, probably essential hypertension, a superimposed genitourinary infection, and terminal middle cerebral artery thrombosis.

General Clinical Discussion

DR. FRIEDMAN: In going over this protocol from a neurological viewpoint, there were a couple of things that bothered me. This man with polycythemia and hypertension, who presented with a very mild onset of just obtundation, dysarthria and subsequently a fall, has 900,000 red cells in his spinal fluid. The accuracy of this many red cells in the spinal fluid surely must be subject to some question,

but would be most compatible with a primary subarachnoid hemorrhage of one sort or another rather than thrombosis as the initial event. Subarachnoid hemorrhage can present with a very gradual course without headache.

We must always, of course, keep in mind subdural hematomas, and it is possible that this man did in fact have a secondary subdural to his primary source of blood inside his skull, but there are several things here that would make me not believe that this was primarily a subdural: First, as Dr. Wall has pointed out, the onset of his symptoms was prior to his fall. Second, the right homonymous hemianopsia would indicate a lesion deeper within cerebral substance itself, and I would seriously doubt that the primary diagnosis is a subdural hematoma.

Dr. Wall has commented upon the subtentorial hemangiomas and I would agree that there are no signs consistent with this diagnosis. I think his course is quite inconsistent with the diagnosis of intraventricular hemorrhage. His terminal episode certainly could have been that, despite the xanthochromic fluid. For the primary source of his hemorrhage I would favor an aneurysm, possibly in the sylvian fissure, to account for his hemianopsia and other findings.

DR. GREENBERG: I have two points: First, one diagnosis that can account for both his hypertension and his erythrocytosis is a pheochromocytoma, although it is to be conceded that he has little else in the protocol to suggest this. The other thing that might be mentioned is polycystic disease, because this has also been associated with erythrocytosis, and there is a known association between polycystic disease and berry aneurysm.

CLINICAL DIAGNOSIS

1. Polycythemia rubra vera.
2. Essential hypertension.
3. Genitourinary infection.
4. Middle cerebral artery thrombosis.

PATHOLOGICAL DIAGNOSIS

1. Polycythemia rubra vera.
2. Widespread intravascular sludging and thrombosis.
3. Pulmonary thromboembolus.

DISCUSSION OF THE PATHOLOGY

DR. CUPPAGE: As Dr. Wall suggested, this is a case of polycythemia. I would like to discuss the findings at autopsy and comment upon one of the common complications of polycythemia.

This case of polycythemia is most likely of a primary nature, or polycythemia rubra. The patient developed some of the vascular complications of polycythemia including widespread intravascular thromboses—in the brain, lung, liver, and kidneys.

Indeed sludging and aggregation were observed in many of the blood vessels throughout the body.

The heart weighed 300 grams. There was hypertrophy of the myocardial fibers consistent with hypertension. Small blood vessel sclerosis was noted in the kidney, which is often associated with hypertension. No primary etiology for the hypertension could be established at autopsy. The hypertension would therefore be designated as essential.

The main pulmonary artery was completely occluded by a recent thromboembolus which extended into the left pulmonary artery. It was adherent to the vessel wall and was in the process of early organization. There were also thromboemboli of variable age within the smaller branches of the vessels of both lungs. Focal pulmonary emphysema of the centrilobular type was identified.

The spleen weighed only 80 grams. It contained an increased amount of iron pigment within the pulp. This finding would be consistent with polycythemia, where a degradation of the increased number of erythrocytes occurs in the spleen.

The liver weighed 1,300 grams. It contained multiple areas of necrosis measuring up to 7 cm. in greatest dimension. Aggregation of erythrocytes and organizing thrombi were found in many of the smaller hepatic blood vessels and sinusoids. There was no evidence of chronic nutritional deficiency, fatty metamorphosis, or cirrhosis.

The kidneys were of normal size and shape. The external and cut surfaces were granular. The blood vessels were sclerotic. Aggregation of erythrocytes and recent thrombi were found in many of the smaller arteries and arterioles. In addition there were multiple infarcts as large as 2 cm. in diameter throughout the parenchyma of the kidneys.

The brain weighed 1,450 grams. Many of the changes in the brain can be related to the fact that the patient was in a respirator for his last two or three days. There was a large amount of swelling, edema, and softness of the right cerebral hemisphere. Multiple areas of necrosis, both true vascular infarcts of varying age and areas of recent hypoxic necrosis, were scattered throughout the brain. The latter may have been due to terminal hypoxia. The aggregation of erythrocytes within many vessels, filling their lumens, suggested sludging or stasis.

So we have a patient with polycythemia, I think most likely polycythemia rubra vera, with a complication we frequently find in polycythemia—intravascular aggregation of erythrocytes with stasis of blood flow, localized hypoxia, and the subsequent development of areas of necrosis throughout many of the organs.

The etiology of an increased number of red cells in polycythemia is obscure. Several theories have been postulated. One is that there is an increased amount of intrinsic factor from the stomach. No proof of this is available. Another is that there is

a primary fibrosis of the arterioles in the bone marrow causing local bone marrow hypoxia and increased erythrocytosis. Again I don't think there is any definite proof of this mechanism. Another possible factor is the increased release of erythropoietin from the kidney. We know that there are instances of increased numbers of red cells due to increased erythropoietin, whatever that happens to be, in cases of primary renal disease. No significant primary renal disease was found here. One would have to conclude that this is a case of polycythemia rubra vera.

Associated with the erythrocytosis of polycythemia rubra vera one finds multifocal intravascular aggregation of erythrocytes, stasis, and thrombosis. While fluid flowing through non-distensible tubes follows Pouiseuille's and Newton's principles of laminar flow, the rheology of the heterogeneous substance (blood) flowing through the circulatory system is far more complex. The anomalous viscosity of blood is increased by the number of high molecular weight substances such as globulins and fibrinogen as well as by the presence of the formed elements, the blood cells. An increase in any of these substances increases the viscosity of blood, which in turn decreases the velocity of blood flow, resulting in sludging of the blood and stasis.

The phenomenon of stasis is especially prevalent in the vessels of small diameter, for here the friction of fluid moving along the walls of the vessel and

cells moving over one another is at a maximum. Any roughening of the intimal surface or decrease in the elasticity of the vessel wall will increase the frictional resistance and predispose to the stasis. Decreased blood flow further increases aggregation of erythrocytes and platelets as well as possibly allowing less dilution of many coagulation factors, resulting in an increased tendency to thrombosis. Nordoy,¹ in fact, produced enhanced intravascular thrombosis in the skin of experimental animals exposed to formalin by initiating either erythrocytosis or thrombocytosis in the animals. He produced erythrocytosis by placing the animals in hyperbaric chambers and produced thrombocytosis by the intraperitoneal injection of thrombopoietic plasma.

General Discussion

DR. FRIEDMAN: Do you have any explanation as to the etiology of the number of red blood cells found in the spinal fluid?

DR. CUPPAGE: This patient did have a subgaleal hematoma which was 5 by 7 cm. in diameter and probably contained at the most about 50 cc. of blood. There was neither subarachnoid nor subdural hemorrhage. We were unable to find a source of bleeding into the cerebrospinal fluid.

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A TRAINING PROGRAM IN MEDICAL LIBRARIANSHIP and communication in the health sciences will be initiated by the School of Library Science of Western Reserve University in July 1967 with the support of a five-year grant of \$377,915 from the U. S. Public Health Service through the Extramural Program of the National Library of Medicine. The program, leading after one year to the degree of M. S. in Library Science, will provide training in both traditional and automated methods of information processing and dissemination within the context of medical libraries, organization of health care and medical research. In addition to courses in information retrieval systems, library automation, and information centers and services, trainees will be offered a specialized subcurriculum in which they will be introduced to the objectives, organization and functions of the several types of health sciences libraries.

The program will utilize the resources and facilities of the School of Library Science and its Center for Documentation and Communication Research, the School of Medicine and the Cleveland Health Sciences Library on the Western Reserve University campus. Six stipends of \$2,400 plus dependency allowance and full payment of fees will be available to applicants of excellence and potential.

For further information contact the Program Director, Professor Alan M. Rees, School of Library Science, Western Reserve University, Cleveland, Ohio 44106.



NEWS AND *Organization Section*

Hill-Burton Grants in Ohio...

Ohio Department of Health Approves 22 Facility Construction Projects for Grants under the Federal Matching Fund Program

STATE APPROVAL has been given for 22 grants under the Federal Hill-Burton program for assistance in the construction of hospitals, health centers, extended care centers, and other medical and health facilities, it was announced by Dr. Emmett W. Arnold, director of the Ohio Department of Health.

The approvals are in conformity with the Revised State Plan which was approved in December and has been forwarded to the United States Public Health Service for processing. Dr. Arnold said there will be supplementary lists of additional grants later. Some have had to be held up temporarily, he said, because of a need for additional information.

The 22 projects for which grants have been approved by the State Health Department are:

Wooster Community Hospital of Wooster, to construct an addition estimated to cost \$3,600,000 was approved for a grant of \$1,100,000.

The Montgomery County Health Department of Dayton to construct a new facility at an estimated cost of \$2,500,000 was approved for a grant of \$833,333.

Timken-Mercy Hospital of Canton, to replace the dormitory unit of the School of Nursing at an estimated cost of \$1,500,000 was approved for a grant of \$500,000. The U. S. Public Health Service previously approved a grant of \$482,468 to construct the educational unit.

Riverside Hospital of Toledo, to construct a dormitory unit to a new School of Nursing at an estimated cost of \$546,120 was approved for a grant of \$182,040.

Wood County Hospital of Bowling Green to construct an addition of 40 beds of which 19 beds are programmed in the Ohio State Plan for Hospital and Medical Facilities Construction was approved for a

grant covering 19 acute beds in the amount of \$150,000. The total estimated cost is \$750,000.

Belmont County Health Department in St. Clairsville, to construct a new Public Health Center at an estimated cost of \$93,000 was approved for a grant of \$31,000.

Oak Hill Hospital in Oak Hill, to construct an extended care unit at an estimated cost of \$250,000 was approved for a grant of \$83,333.

Good Samaritan Hospital in Sandusky, to construct an extended care unit of 36 beds at an estimated cost of \$350,000 was approved for a grant of \$100,000.

H. B. Magruder Hospital of Port Clinton, to construct an extended care unit of 30 beds at an estimated cost of \$400,000 was approved for a grant of \$133,333. The hospital plans other expansions which brings the total estimated cost up to \$2,000,000.

The Morey Pavilion of Marysville, to construct a 40-bed nursing home at an estimated cost of \$900,000 was approved for a grant of \$250,000.

The Mansfield General Hospital of Mansfield, to construct a 100-bed extended care unit and enlarge the x-ray department at an estimated cost of \$1,100,000 was approved for a grant of \$333,333.

The Middletown Hospital of Middletown, to construct an extended care unit of 82 beds at an estimated cost of \$800,000 was approved for a grant of \$240,000.

Putnam County Commissioners of Ottawa, to construct a new 30-bed nursing home in connection with a new county home at an estimated cost of \$450,000 was approved for a grant of \$150,000. The overall estimated cost of the county home is \$850,000.

Sheltering Arms Hospital of Athens, to construct a 25-bed extended care unit in a new hospital to be constructed was approved for a grant of \$167,000.

The estimated cost of the extended care unit is \$500,000.

The Toledo Health and Retiree Center of Toledo, to construct a nursing home unit of the center at an estimated cost of \$3,000,000 was approved for a grant of \$900,000.

The Euclid-Glenville Hospital of Cleveland to construct a 100-bed extended care unit at an estimated cost of \$1,500,000 was approved for a grant of \$500,000.

The Wesley Glen Nursing Home of Columbus, to construct a 46-bed nursing home unit in connection with their retirement center at an estimated cost of \$460,000 was approved for a grant of \$100,000.

New London Hospital of New London, to construct an addition to the hospital at an estimated cost of \$200,000 was approved for a diagnostic and treatment center grant of \$20,000. This includes the x-ray, laboratory, and emergency units only.

Bethesda Hospital of Cincinnati, to expand and modernize the outpatient department of the hospital was approved for a grant of \$300,000. The overall program of the hospital is estimated to cost \$6,000,000.

Lake County Society for Crippled Children and Adults of Painesville, to construct a rehabilitation center facility at an estimated cost of \$152,000 was approved for a grant of \$50,000.

The Rehabilitation Center of Lorain County, Lorain, to construct a new facility at an estimated cost of \$210,000 was approved for a grant of \$70,000.

Dodd Hall of Ohio State University College of Medicine, Columbus, to construct 40 rehabilitation center beds was approved for a grant of \$200,000.

Research Grants Authorized

Two physicians at Highland View Hospital, in Cleveland, head research projects supported by recent substantial grants.

Dr. Olgierd Lindan, chief of the metabolic ward at the hospital, and associate professor at Western Reserve University, was authorized a grant of \$578,000 from the Department of Health, Education, and Welfare for research into automated monitoring devices for certain patients. Case Institute engineers are also working on the project.

Dr. Charles Long, acting director of the Department of Physical Medicine, and associate professor at Western Reserve, heads a project financed by a \$393,000 grant from HEW. Research is in the field of muscle control and evaluation of new devices for paralyzed patients. Dr. John Lane is another researcher on the project.

Dr. Deirdre O'Connor, of Toledo, has been appointed Wood County health commissioner. She succeeds Dr. Robert C. Markey, who resigned to take a position with the State Health Department.

M. D.'s in the News

Dr. Bruce D. Graham, professor and chairman of pediatrics in the Ohio State University College of Medicine, spoke recently to graduate students of the University of Michigan School of Public Health, where he described the Pre-School, School and Youth Project in Franklin County and how it fits into other community health activities.

* * *

Dr. Edward P. Monaghan was the subject of a feature article in the *Cleveland Plain Dealer* on the occasion of his retirement from active practice after a professional career of some 65 years.

* * *

Dr. Edwin R. Westbrook has been elected chairman of the board of trustees of Hillside Hospital, Warren. Dr. Westbrook is Councilor of the Sixth District of the Ohio State Medical Association.

* * *

Dr. Ernest W. Johnson, chairman of the Department of Physical Medicine at Ohio State University, addressed a parents' group of the Franklin County Society for Crippled Children in Columbus.

* * *

Dr. John J. Grady, vice-president of the Academy of Medicine of Cleveland, was speaker at a meeting of the St. James Women's Guild in Lakewood, where he spoke on the topic, "Whatever Happened to the Old-Fashioned Doctor?"

* * *

Dr. Sanford Press, Steubenville, addressed the Toronto (Ohio) Parent-Teachers Association, using as his topic, "What Children Want to Know About Sex."

* * *

Dr. James E. Loggins, Galion, recently was re-elected to his third term on the Galion Board of Education.

* * *

Dr. James H. Williams, assistant dean of the Ohio State University College of Medicine, gave a Sunday afternoon talk at the Center for Science and Industry in Columbus on the topic "The Medical Profession."

* * *

Dr. Byers W. Shaw, Washington Court House, has been named president of the local Board of Education. Dr. Robert U. Anderson is a member of the board.

* * *

Dr. Carl R. Swanbeck participated in a panel discussion at the Berlin-Heights Parent-Teacher meeting where the topic of discussion was "Sex Education — Whose Responsibility?"

Geauga County's 100th Anniversary ...

Centennial Is Celebrated with Gala Dinner Dance; Members And Guests Hear Report on 100 Years of Progress in Area

The following article is adapted from a report which appeared in the December 5, 1966, issue of the *Geauga Times-Leader*.

* * *

MUNSON—The 100th Anniversary of the Geauga County Medical Society was celebrated with a dinner dance at Berkshire Hills Country Club Saturday night, December 3.

Many doctors from the county and state were among the 120 guests.

Special honor was given Dr. Isa C. T. Cramton, 90, an important figure in the Society's history, who served as secretary-treasurer for 40 years.

DR. CRAMTON was presented with the first piece of the 100th anniversary cake by Mrs. Bruce Andreas, wife of the society's president.

The Geauga County Medical Society, to which Dr. Cramton had dedicated herself for nearly half a century, was founded only 10 years before her birth.

Other highlights were speeches given by seven doctors; Dr. Andreas' reading of a report of the Society's first meeting on Aug. 25, 1866, from the ori-

ginal book; an outline of the society's history; and an original poem on the tasks of a country doctor.

DR. WILLIAM REED, acting as master of ceremonies, introduced Dr. Bruce F. Andreas who in turn introduced the special guests.

Special guests were Dr. Lawrence C. Meredith, president of the Ohio State Medical Association; Dr. Henry A. Crawford, Past President of OSMA.

Officers of the Cleveland Academy of Medicine, Dr. David Fishman, president; Dr. Eldon Weckesser, president-elect, and Dr. Fred Kelly, secretary-treasurer.

"We are here tonight celebrating not only our anniversary but those who cared for those who went before us," Dr. Andreas said.

Dr. Alton Behm of Geauga gave some of the history of the society.

The Geauga County Medical Society was founded August 25, 1866, as the Western Reserve Medical Society, Dr. Behm said.

In March of 1867, the name was changed to the Geauga County Medical Society . . . The first meeting was held at the county court house at Chardon. Eleven members were elected, Dr. Behm reported.

DR. BEHM gave a three-phase history of the



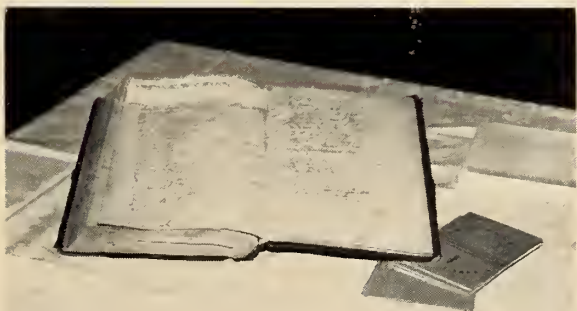
At the centennial celebration speakers table, from left: Rev. and Mrs. William Stickley; Dr. and Mrs. Henry A. Crawford; Dr. and Mrs. Lawrence C. Meredith; Dr. Alton Behm, reading history of Society; Dr. William Reed, master of ceremonies, and Mrs. Reed; Dr. and Mrs. Bruce Andreas. Also at the speakers' table, but not shown, were Dr. David Fishman, president of the Cleveland Academy, and Mrs. Fishman.



Mrs. Bruce F. Andreas cuts the cake commemorating the Centennial of the Society.



Dr. Isa Teed Cramton receives a portion of the centennial cake from Dr. Bruce F. Andreas, Society president, while Dr. Walter Corey looks on.



Old leather-bound volume, containing minutes of the Geauga County Medical Society from 1866 to 1946 was recently turned over to the Society by Dr. Cramton, and signed by all guests at the centennial celebration.

society, including early fee bills, financial and organizational development and the establishment of Geauga Community Hospital on July 20, 1959. He also gave a history on some of Geauga's outstanding doctors.

Dr. Cramton filled the group in on war losses and sacrifices made by doctors she had known.

Dr. Walter C. Corey gave examples of the changes he witnessed in medicine by personal experiences and read one of his untitled poems on the difficult tasks of a country doctor.

DR. LEROY WRIGHT, vice president of the Board of Trustees of Geauga Community Hospital, read a letter from Hospital Trustee President William J. Barnes who congratulated the society on its anniversary.

Dr. Andreas thanked Dr. Chanour K. Adrian, society vice-president; Dr. Arturo J. Dimaculangan, secretary-treasurer; Dr. Shigeki Hayashi, program chairman; and Mrs. Martha Withrow, executive secretary, who made the program possible; and to the Rev. William Stickle, president of the Geauga County Ministers Association who gave the invocation.

Before the dance started, Master of Ceremonies Dr. Reed paged two doctors back to duty, reminding everyone that, anniversary or no, the practice of medicine does not stop.

Carroll County Announces Third Annual Seminar

The Carroll County Medical Society will present its third annual Postgraduate Medical Seminar at the Atwood Yacht Club, RFD#1, Dellroy, on Wednesday, March 29.

The following speakers will present the program: William Schubert, M.D., director of the Clinical Pediatric Center, Children's Hospital, and associate professor of pediatrics, University of Cincinnati College of Medicine — "Iron Deficiency Anemias in Relation to Nonanatomic Lesions of the Gut."

Paul Palmisano, M.D., fellow in pediatric pharmacology, Medical College of Alabama and former deputy director, Bureau of Medicine, Federal Drug Administration — "Diagnosis and Treatment of Enuresis."

Richard E. Goldsmith, M.D., associate professor of medicine, University of Cincinnati College of Medicine and a member of the Metabolic and Radioisotope Laboratories — "Laboratory and Clinical Diagnosis of Thyroid Disease."

Stanley Garber, M.D., professor of obstetrics and gynecology and former chief of the Department of Obstetrics, University of Cincinnati College of Medicine — "Family Planning."

Dr. Garber will also speak at the combined noon luncheon for the doctors and their wives on the topic, "Marital Problems."

A full day's ladies program for the wives is being arranged.

OSU's New Basic Science Structure



Ground-breaking ceremonies were held recently and set the stage for construction of a \$13.5 million Medical Basic Science Building, one of the largest projects in Ohio State University's current construction program. The architect's sketch shows the structure as it will appear in view toward the northeast. Facilities in the five-level wing to the right will include multi-disciplinary laboratories for medical students. An administrative wing adjoins at left. The north-south street shown in the foreground is Belmont Avenue; the east-west street, West 9th Avenue.

Several Departments To Be Housed When Building Is Completed

Modern housing facilities for several departments will be provided when the new Basic Science Building is completed on the extended area of the Ohio State University Campus in Columbus. Ground-breaking ceremonies were held recently, opening the way for early construction on the major project.

The Basic Science Building for the College of Medicine, to be constructed at an estimated cost of \$13.5 million, will be one of the largest projects in the University's current construction program.

Funds for the building will come from the Ohio bond issue passed by the voters in 1963 and from approximately \$6,013,546 in federal matching grants.

The Basic Science Building is the second structure to get under way in the developing campus area recently cleared between West 9th and 10th Avenues, and between Neil Avenue and Perry Street. Housed

in the building will be the Departments of Pathology, Pharmacology, Medical Microbiology, Anatomy, Physiology, and Physiological Chemistry. The first two floors of the five-level facility will provide multi-disciplinary laboratories for the first- and second-year medical students.

Another major project now under construction in the block adjoining Neil Avenue is the School of Nursing Building. This structure with three stories above ground will be built at an estimated cost of \$2,170,000. A million dollars earmarked from the Ohio bond issue and a federal grant will finance most of the cost. The new facility will increase the nurse student capacity from 231 to an estimated 308.

Plans for the Basic Science Building call for a two-story annexed wing containing two auditorium-type classrooms, each seating 275 students. Also included in the wing will be a student lounge, staff lounge, closed-circuit television teaching facilities, and administrative offices of the College of Medicine.

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Congressman
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The Honorable JOHN M. ASHBROOK

CONGRESSMAN
SEVENTEENTH OHIO DISTRICT

will speak on . . .

The Role of the Physician in Politics

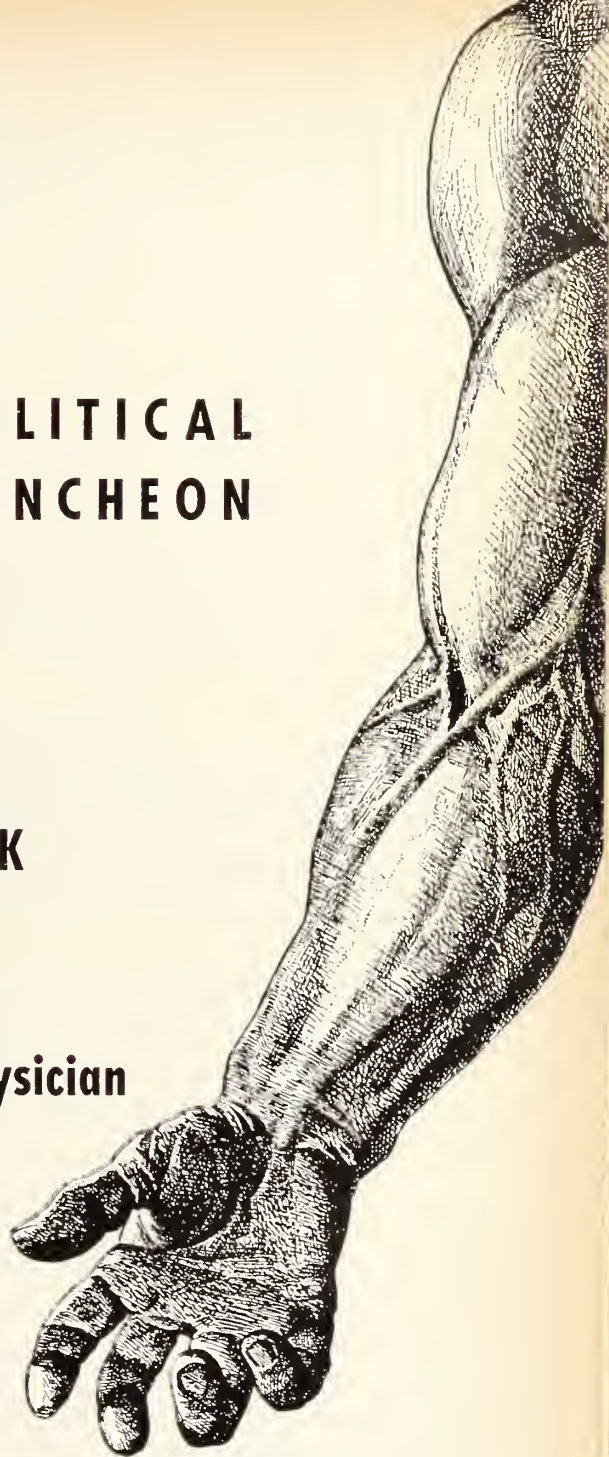
11:45 A.M. Cash Bar

12:15 P.M. Luncheon

1:00 P.M. "OMPAC Hits the Bull's Eye"—
A Progress Report

1:15 P.M. The Role of the Physician in Politics
Hon. John M. Ashbrook

Congressman Ashbrook will speak about why it is important for *all* physicians to be active in politics and will explain the role active physicians played in a successful campaign.

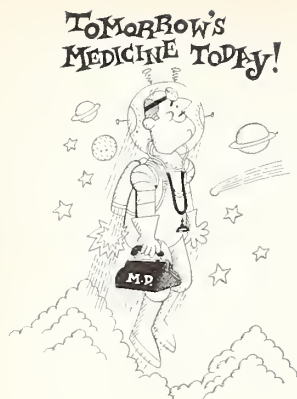


TICKETS . . .

\$5.00 per person

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The Ohio State Medical
Association



Highlights

THE OHIO STATE MEDICAL ASSOCIATION'S

1967 ANNUAL MEETING

MAY 15-MAY 19 • COLUMBUS

Sheraton-Columbus
Motor Hotel

Veterans Memorial
Building

WEDNESDAY, MAY 17

1:30 P.M.

Main Auditorium, Veterans Memorial Building

GENERAL SESSION

"EDUCATING PATIENTS ABOUT SEXUAL RELATIONSHIPS"

Featuring

"Sexual Attitudes and Sexual Problems in Medical Practice"

MARY S. CALDERONE, M.D., New York City
Executive Director, Sex Information and Education Council
of the United States

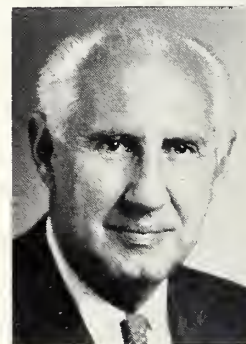
and

"Contraceptive Problems in Medical Practice"

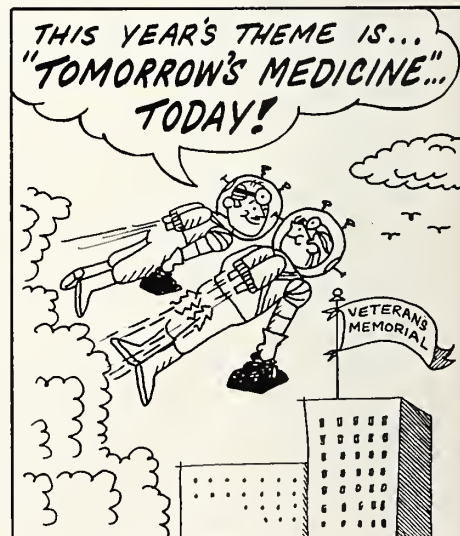
ALAN F. GUTTMACHER, M.D., New York City
President, Planned Parenthood Federation of America, Inc.



Dr. Calderone



Dr. Guttmacher



THURSDAY, MAY 18

1:30 P.M.

GENERAL SESSION

Main Auditorium

Veterans Memorial Building

"DRUG REGULATIONS AND COMPULSORY GENERIC PRESCRIBING"

A PANEL DISCUSSION

Moderator

PERRY R. AYRES, M.D., Columbus, Editor, The Ohio State Medical Journal

The Participants

JAMES L. GODDARD, M.D., Washington, D.C., Commissioner, Food and Drug Administration, Department of Health, Education, and Welfare.

MAX S. SADOVE, M. D., Chicago, Illinois, Professor and Head of the Department of Anesthesiology, University of Illinois Research and Educational Hospitals; Professor and Head of the Division of Anesthesiology, University of Illinois College of Medicine.

C. JOSEPH STETLER, Washington, D. C., President, Pharmaceutical Manufacturers Association.

FRIDAY MAY 19

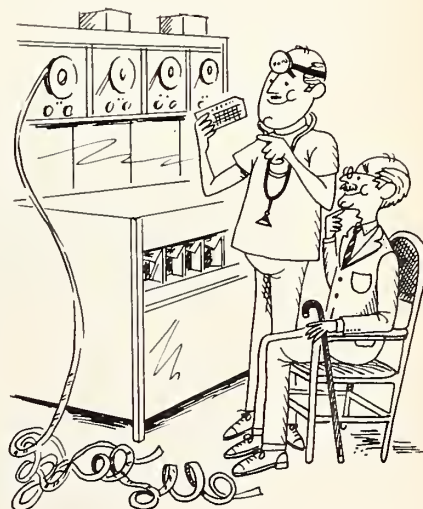
11:00 A.M.

Assembly Hall, Veterans Wing, First Floor
Veterans Memorial Building

"COMPUTERIZED AND AUTOMATED MEDICINE"

C. A. CACERES, M. D., Washington, D. C., Chief, Instrumentation Field Station, Heart Disease Control Program, Division of Chronic Diseases, Department of Health, Education, and Welfare.

MORRIS F. COLLEN, M. D., Oakland, California, Director, Medical Methods Research, The Permanente Medical Group.



FRIDAY, MAY 19
1:30 P.M.

GENERAL SESSION

Main Auditorium, Veterans Memorial Building

Featuring...

MILFORD O. ROUSE, M. D.

Dallas, Texas

PRESIDENT-ELECT

THE AMERICAN MEDICAL ASSOCIATION



Dr. Rouse

Alice Stone Woolley Memorial Lecture At OSMA Annual Meeting

The Alice Stone Woolley Memorial Lecture of the American Medical Women's Association will be delivered at a General Session during the 1967 Annual Meeting of The Ohio State Medical Association, May 15-19 in Columbus.

Mary S. Calderone, M. D., New York City, Executive Director of the Sex Information and Education Council of the United States, will present the Lecture on the subject, "Sexual Attitudes and Sexual Problems in Medical Practice." The Lecture will be presented at a General Session devoted to the topic, "Educating Patients About Sexual Relationships," on Wednesday, May 17 at 1:30 P. M. in the Main Auditorium of the Veterans Memorial Building in Columbus.

The Lecture will be introduced by Margaret J. Schneider, M.D., Cincinnati, Immediate Past President of the American Medical Women's Association. Dr. Schneider explained the establishment of the lecture fund:

During the end of her term as president of AMWA (1944-1945), Dr. Alice Stone Woolley suffered a coronary occlusion at the annual meeting in San Francisco. She recovered sufficiently to attend the meeting in New York in June, 1946, but she died in November of that same year. To honor her as an outstanding physician and as a most active member, AMWA established an Alice Stone Woolley Memorial Fund. Dr. Theresa Scanlon was made chairman and has continued her interest in this fund up to the present.

All members were given an opportunity to contribute and by 1947 \$3,500 had been collected. It was decided that this money should be used to pay the expenses involved for a speaker, as required, for the

annual meetings. In 1961 the Alice Stone Woolley Memorial Committee recommended the formation of a standing committee to be known as the Lectureship Committee, whose duties were (1) to develop a program of lectureship for the Association, (2) to develop a roster of speakers for annual, regional, or other meetings, and (3) to provide reimbursement of speakers through an honorarium from the Association funds.

Provisions in the OSMA Bylaws Pertaining to Nomination Of President-Elect

Attention is called to provisions in the Bylaws of the Ohio State Medical Association pertaining to the nomination and election of the President-Elect at the OSMA Annual Meeting. The President-Elect and other officers are elected by the House of Delegates, meetings of which will be held during the Annual Meeting in Columbus, May 15-19.

Nominations of the President-Elect are to be made 60 days in advance of the meeting at which election takes place and information on nominations published in *The Journal*, unless these provisions are waived by a two-thirds vote of the House of Delegates. The 60-day deadline is March 20.

The part of the OSMA Bylaws pertaining to this procedure is Section 1 (a), entitled "Nomination of President-Elect."



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Activities of County Societies . . .

First District

(COUNCILOR: PAUL N. IVINS, M. D., HAMILTON)

HAMILTON

"Current Status of Organ Transplantation" was the topic of a panel discussion during the January 17 meeting of the Academy of Medicine of Cincinnati. Participants included the following persons:

Dr. Ben Eiseman, professor and chairman of the Department of Surgery, University of Kentucky School of Medicine, moderator;

Dr. James D. Hardy, professor and chairman of the Department of Surgery, University of Mississippi; and

Dr. John P. Merrill, director of the Cardiorenal Section, Peter Bent Brigham Hospital, Harvard University.

Among specialty societies associated with the Academy of Medicine of Cincinnati and which hold regular meetings for scientific purposes are the following:

American Medical Women's Association, Branch 11.
Cincinnati Society of Anesthesiologists.
Cincinnati Dermatological Society.
Southwestern Ohio Society of Family Physicians.
Cincinnati Society of Internal Medicine.
Cincinnati Medical Association.
Cincinnati Society of Neurology and Psychiatry.
Cincinnati Obstetrical and Gynecological Society.
Cincinnati Society of Ophthalmology.
Cincinnati Orthopaedic Society.
Cincinnati Otolaryngological Society.
Cincinnati Society of Pathologists.
Cincinnati Pediatric Society.
Ohio Valley Proctologic Society.
Radiological Society of Greater Cincinnati.
Cincinnati Rheumatism Society.
Cincinnati Surgical Society.
Veteran Physicians Society of Greater Cincinnati.

Second District

(COUNCILOR: THEODORE L. LIGHT, M. D., DAYTON)

MIAMI

Dr. William C. Rigsby, assistant professor of obstetrics and gynecology at Ohio State University College of Medicine, discussed "Rh Factor Problems" at the January 10 meeting of the Miami County Medical Society at the Troy Country Club.

Third District

(COUNCILOR: FREDERICK T. MERHANT, M. D., MARION)

AUGLAIZE

Members of the Auglaize County Medical Society met on January 5 at Koch's Restaurant, St. Marys, for the monthly dinner meeting. Guest speaker was Kenneth Langdon, Bowling Green, who is associated with the Nationwide Insurance Company. He discussed medical aspects of the Medicare program.

ALLEN

Dr. William Culbertson, Cincinnati, associate professor of surgery at the University of Cincinnati College of Medicine, addressed the Lima and Allen County Academy of Medicine at its January 17 meeting. His subject was "Tetanus and Gas Gangrene."

Also speaking at the meeting was Lyle Lee, Allen County welfare director, who discussed community welfare programs.


Fourth District

(COUNCILOR: ROBERT N. SMITH, M. D., TOLEDO)

LUCAS

The Academy of Medicine of Toledo and Lucas County announced the following program features during January:

January 12 — 65th Annual Academy Meeting at



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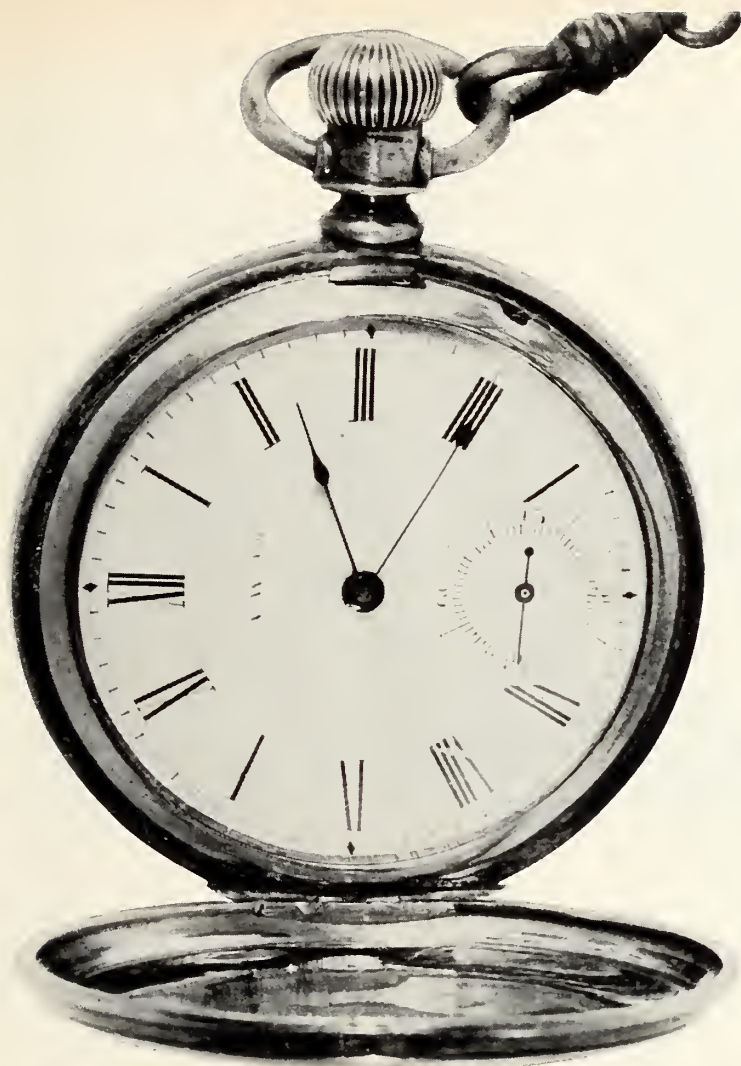
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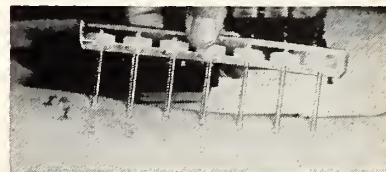
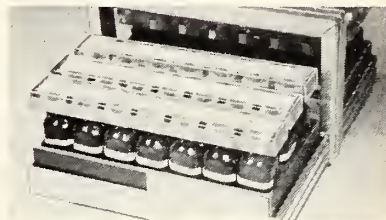
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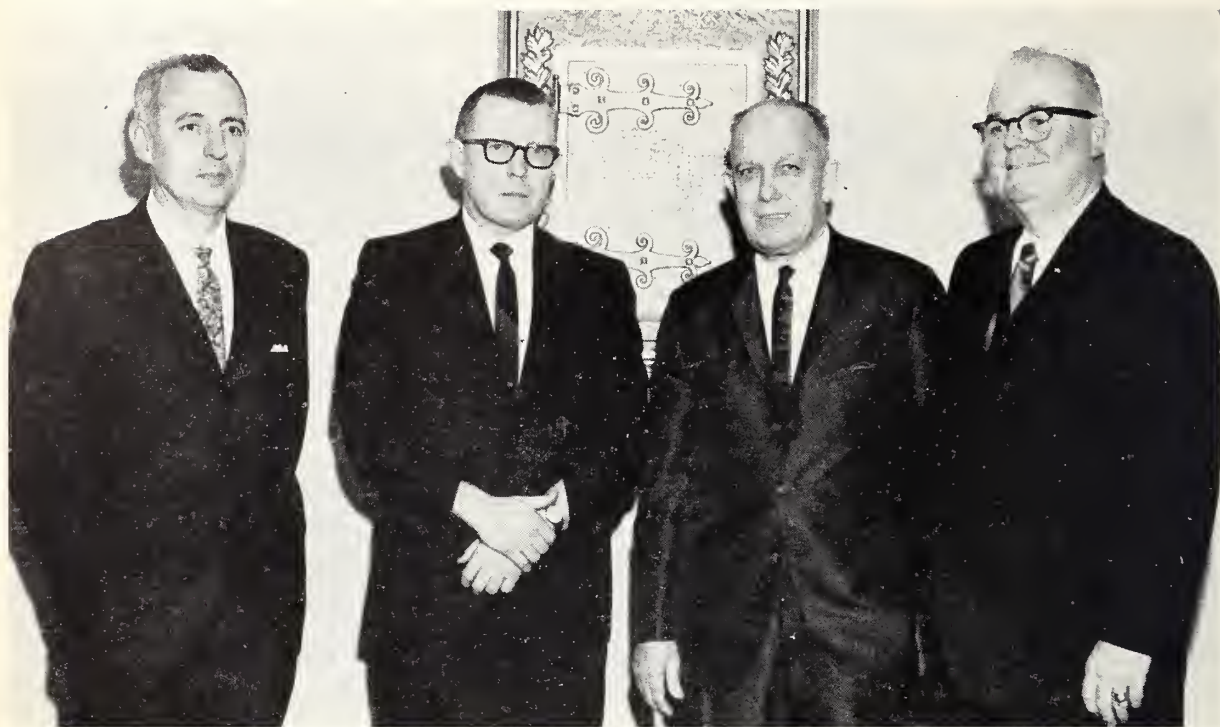


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Dignitaries at Butler County Meeting



President Lawrence Meredith and President-Elect Robert Howard, of the Ohio State Medical Association, are flanked on the left by Dr. Brady Randolph, Hamilton orthopaedic surgeon, President of the Butler County Medical Society, and on the right by Dr. Paul Ivins, Hamilton internist, First District Councilor of the Ohio State Medical Association, at the January meeting of the local society held at the Elks Country Club, with 78 members present.

Dr. Meredith presented the principal address and was introduced by Dr. Howard. Dr. Walter H. Roebll, Jr., of Middletown, is President-Elect of the Butler County Medical Society, and Dr. Joseph Hufschmitt, Hamilton, is Secretary-Treasurer. The Butler County Society has 185 members.

the Commodore Perry Hotel. Guest speaker: Henry J. Taylor, whose topic was "Looking Ahead at Home and Abroad."

January 20 — A panel discussion entitled "Coronary Heart Symposium" with Dr. H. C. Mack as chairman.

January 27 — A discussion on "The Toledo Medical School and Regional Planning" led by Dr. Glidden Brooks and Dr. F. F. A. Rawling.

Fifth District

(COUNCILOR: P. JOHN ROBECHKE, M. D., CLEVELAND)

CUYAHOGA

A feature article in a recent issue of *The Bulletin* of the Academy of Medicine of Cincinnati describes the present organization and future plans of the Cleveland Clinic Band, a group composed almost entirely of physicians.

Sixth District

(COUNCILOR: EDWIN R. WESTBROOK, M. D., WARREN)

CARROLL

Dr. William G. Wasson, Canton, addressed a meeting of the Carroll County Medical Society on January 5 on the topic "Heart Resuscitation." The meeting was held in the Carrollton Municipal Building.

MAHONING

Dr. Harold J. Reese was installed as president at the annual banquet of the Mahoning County Medical Society on January 17. Wives and families of members attended to watch the installation ceremonies and to hear the guest speaker, Dick Modzelewski, veteran quarterback of the Cleveland Browns, who related experiences from 14 years of pro football. Modzelewski was introduced by Dr. Jack Schreiber, program chairman.

Newly installed officers were: Dr. Robert R. Fisher,

president-elect, and Dr. M. C. Raupple, treasurer. Dr. G. E. Decicco was installed as delegate to the Ohio State Medical Association, and new alternates are Dr. Joseph W. Tandatnick and Dr. William D. Loeser. New members of the society council are Drs. R. L. Jenkins, Louis Bloomberg, Henry Holden and Robert G. Warnock. Dr. Elias Saadi was named editor of the society Bulletin and Dr. John F. Stotler, public relations director.

Dr. F. A. Resch, retiring president received an appreciation plaque and a past-presidents pin. Dr. Jenkins, retiring editor, received a bound volume of the 1966 Bulletin.

SUMMIT

The Summit County Medical Society held its monthly membership meeting on February 7 at the Children's Hospital in Akron. Subject for discussion was the new Title 19 Medicare programs and the new nursing home coverage under Title 18. Preston J. Jolly, representative of Nationwide Insurance Company, was speaker.

TRUMBULL

The annual dinner-dance honoring new officers of the Trumbull County Medical Society and the Woman's Auxiliary was held at the Trumbull Country Club. Dr. John F. McGreevey, outgoing president, presented the gavel to the incoming president, Dr. Allan L. Schaffer. President-elect is Dr. Donn F. Covert, and secretary-treasurer is Dr. William Barba.

Clayton L. Scroggins, head of Clayton L. Scroggins Associates, professional business management organization of Cincinnati, was guest speaker for the February 15 meeting of the Trumbull County Medical Society. His topic was "The Economics of Medical Practice."

The dinner meeting was held at the Trumbull Country Club.

Tenth District

(COUNCILOR: RICHARD L. FULTON, M. D., COLUMBUS)

FRANKLIN

Two specialty societies joined with the Academy of Medicine of Columbus and Franklin County in providing program features for the annual meeting of the academy on January 17.

A social hour and dinner preceded the meeting at the Neil House in downtown Columbus.

Following is a summary of featured speakers and topics:

For the Neuropsychiatric Society of Central Ohio, Dr. Jerome Levine, National Institute of Mental Health, spoke on the topic, "LSD — Past Results and Future Prospects." Dr. Levine is assistant chief of the Psychopharmacology Research Branch of NIMH and has written extensively concerning LSD.

The guest speaker presented by the Columbus Society of Anesthesiologists was Edgar E. Baker, of the firm of Merrill Lynch, Pierce, Fenner and Smith, Columbus. He spoke on the subject, "The Current Status of the Stock Market."

Dr. Tom F. Lewis, Academy president, was moderator for the third discussion group on the topic, "Your Academy Business." Much of the business discussion was on governmental medical programs.

Eleventh District

(COUNCILOR: WILLIAM R. SCHULTZ, M. D., WOOSTER)

ERIE

The Erie County Medical Society began its year of activities with a meeting at the Surf Lounge, Sandusky, early in January.

It was reported that a measles vaccination clinic was to be held at the Armory for the benefit of persons who would not normally receive vaccine from the family doctor.

Speaker for the meeting was Preston Jolley, associated with the Nationwide Insurance Company, who discussed phases of the Medicare program.

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against the usual gram-negative urinary pathogens

Why use five...where **one** will do?



In a recent 217-patient hospital study,¹ urinary tract infections were treated with a variety of widely prescribed antimicrobial agents including: a sulfonamide (40 patients), chloramphenicol (20 patients), nitrofurantoin (33 patients), nalidixic acid (30 patients), tetracycline (27 patients), colistimethate sodium (22 patients) ... and 2 combinations of 5 agents each (45 patients). The 2 combinations were selected to afford maximal theoretical antibacterial coverage against the usual urinary pathogens. They were (1) tetracycline, chloramphenicol, nitrofurantoin, ristocetin and polymyxin B; and (2) tetracycline, chloramphenicol, erythromycin, nitrofurantoin and colistimethate sodium.

This clinical study shows that the two combinations of antibiotics were not superior to some of their single components. The authors point out that antibiotic antagonism often negates theoretical advantages of multiple therapy. Coly-Mycin Injectable (colistimethate sodium) was one of the single components that was shown to be equal to the combinations and eradicated bacteriuria in two-thirds of the patients.

Theoretical choice of multiple antibacterial therapy has been shown to be no more effective than one well-chosen agent which also offers least patient exposure to possible side reactions, toxicities, allergic manifestations and higher drug costs.

1. McCabe, W. R., and Jackson, G. G.: New England J. Med. 272:1037, 1965.

in gram-negative urinary tract infections often the single well-chosen agent



Coly-Mycin® Injectable

(colistimethate sodium)

Indications: Especially indicated for the treatment of severe acute and resistant chronic urinary tract infections due to sensitive strains of gram-negative organisms. Also indicated in respiratory tract, surgical, wound and burn infections and in septicemia due to sensitive organisms. Particularly indicated when any of these infections are caused by sensitive strains of *Pseudomonas aeruginosa*.

Adverse Reactions: Occasional reactions such as circumoral paresthesias, tingling of the extremities, pruritus, vertigo or dizziness may occur. Reduction of dosage may alleviate symptoms. Therapy need not be discontinued, but such patients should be observed with extra care.

Warning: Patients should be cautioned not to drive vehicles or use hazardous machinery while on therapy.

Precautions: In cases of impaired or suspected renal impairment, use with greater caution and reduce dosage in proportion to extent of impairment. Transient elevations of BUN have been reported. As a routine precaution, appropriate blood studies should, therefore, be made during prolonged therapy.

As with all polypeptides, the possibility of muscular weakness, including apnea, due to inadvertent overdosage or normal dosage in the presence of impaired renal function, should not be overlooked. In cases of apnea, medication should be promptly discontinued and assisted respiration given until serum levels fall and normal breathing is restored.

Other antibiotics, such as kanamycin, streptomycin, dihydrostreptomycin, polymyxin, and neomycin, may also have varying neurotoxic or nephrotoxic potential. They should be used with great caution concomitantly with Coly-Mycin Injectible (colistimethate sodium).

For deep intramuscular injection only.

Dosage: By the I.M. route only, in 2 to 4 divided doses ranging from 1.5 to 5 mg./Kg./day (0.7 mg. to 2.3 mg./lb./day). Average adult dose is 2.5 mg./Kg./day (1.1 mg./lb./day). In the presence of bacteremia, septicemia, or other serious infection, greater than average doses may be required; however, maximum daily doses should not exceed 5 mg./Kg. (2.3 mg./lb.) where renal function is normal.

Not recommended against *Proteus*.

Colistin is also available (as colistin sulfate) in: Coly-Mycin® Pediatric for Oral Suspension (not for systemic use), and Coly-Mycin® Otic with Neomycin and Hydrocortisone.

Full information is available on request.



Preview for Medical Students ...

Practicing Physicians Tell Junior Medical Students in Two Ohio Medical Schools About the Practical Side of Practice

THE 1967 Annual OSMA Special Talks for Medical Students at the University of Cincinnati and the Ohio State University were a resounding success at both schools. A combined attendance of over 250 junior medical students, their wives (or girl friends), heard practical pointers from outstanding physicians on everyday aspects of medical practice.

The program at each school consisted of an afternoon of practical pointers on the legal, economical, and family aspects of setting up practice, followed with a social hour, complimentary dinner, and an evening program with hints for involvement of the physician in community activities and organized medicine. The wives and girl friends were the target for one of the evening presentations on what it's like to be a physician's wife.

The program for the OSU medical juniors was held at the Fort Hayes Hotel on February 4, and marked the 16th time the "special talks" have been held at this school. The Cincinnati Academy of Medicine was the site for the program for the Cincinnati students on January 28. This was the 15th time this program has been conducted at Cincinnati.

This series of special talks is sponsored by the OSMA Committee on Rural Health in cooperation with the Colleges of Medicine and campus chapters of the Student American Medical Association.

One of the features of the program was the presentation of a stipend on behalf of OSMA to assist the local Student AMA chapter presidents in attending the National Student AMA Annual Meeting. Mr. Michael Asher is president of the OSU chapter and Mr. Michael Szpak is president of the Cincinnati chapter.

Paul N. Ivins, M.D., Hamilton, First District Councilor, presided at the Cincinnati program, and Richard L. Fulton, M.D., performed the same duty at the OSU program.

The program and speakers were as follows: "The Family Physician: His Practice," by Victor R. Frederick, M.D., Urbana; "The Economics of Medical Practice," by Charles H. McMullen, M.D., Loudonville, (at OSU), by John R. Polsley, M.D., North Lewisburg, (at U. of C.); "The Art of Medicine," by Harold C. Smith, M.D., Van Wert, (at OSU), by Jerry L. Hammon, M.D., West Milton, (at U. of C.); "Family Practice: A Recognized Specialty," by Jasper M. Hedges, M.D., Circleville.

"The Physician's Wife," by Mrs. Victor R. Frederick, Urbana; "The Physician and His Community," by Robert E. Reiheld, M.D., Orrville; and "The Physician and His Medical Society," presented by Lawrence C. Meredith, M.D., Elyria, president of OSMA.



An important part of the program at each school was an informal social period during which students talked face to face with practicing physicians. At the left, Dr. Polsley chats with a couple, while at the right, Dr. Hedges gives a student some pointers.

**When thiazide
or reserpine alone
won't keep**

**Establish and
maintain
early, more
decisive control
of blood pressure**

**BLOOD
PRESSURE
SURE
DOWN**

When blood pressure won't stay down despite initial therapy—when complaints of headache, fatigue or dizziness are often voiced—it may be time for a change to DIUTENSEN-R.

DIUTENSEN-R is thiazide and reserpine plus cryptenamine—a rational, comprehensive therapy to help establish and maintain early, more decisive control of blood pressure.

The cryptenamine in DIUTENSEN-R helps improve normal vasodilating reflexes while the thiazide and reserpine components maintain vasorelaxant, sedative, and saluretic benefits. Cryptenamine lowers pressoreceptor reflex thresholds (which may be abnormally high in hypertension)—“resets” pressoreceptors to function at more nearly normotensive levels.

Early, more decisive control with DIUTENSEN-R helps secure continuing benefits—may reduce or even obviate the need for poorly tolerated drugs later in therapy.

Indications: DIUTENSEN-R may be employed in all grades of essential hypertension.

Dosages: Usual dose is 1 tablet twice daily, at morning and evening meals. However, adjustment of dosage to suit individual circumstances may be required. Please refer to package insert for full particulars.

Side effects and precautions: The side effects observed with patients on DIUTENSEN-R have been of a mild and nonlimiting nature. These include occasional urinary frequency, nocturia, nasal congestion, muscle cramps, skin rash, joint pains due to gout and nausea and dizziness which have been reported for the individual components. Most of these symptoms disappear while the drug is continued at the same or lower dosage level. The concomitant use of digitalis and DIUTENSEN-R may increase the possibility of digitalis-like intoxication. If there is evidence of myocardial irritability (extrasystoles, bigeminy or AV block), dosage of DIUTENSEN-R should be reduced or discontinued. Nocturia in patients with marginal cardiac status and salt and fluid retention can be effectively controlled by limiting the time of administration to early afternoon. DIUTENSEN-R should not be used in patients with a known intolerance to reserpine. Package inserts furnish a complete summary of recommended cautions related to each of the ingredients of DIUTENSEN-R.

*As tannate salts equivalent to 130 Carotid Sinus Reflex Units.

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Parepectolin for quick relief of acute diarrhea
...soothes colicky pain with paregoric
...consolidates fluid stools with pectin
...adsorbs irritants with kaolin, and protects
intestinal mucosa

In children, Parepectolin may be used to control diarrhea promptly and prevent dehydration, until etiology has been determined. In some cases, Parepectolin may be all the therapy necessary.



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Each fluid ounce of creamy white suspension contains:
Paregoric (equivalent)..... (1.0 dram) 3.7 ml.
Contains opium (¼ grain) 15 mg. per fluid
ounce.
warning: may be habit forming
Pectin (2½ grains) 162 mg.
Kaolin (specially purified).... (85 grains) 5.5 Gm.
(alcohol 0.69%)
Usual Children's Dose: One or two teaspoonfuls
three times daily.



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Emotional Problems of Children Will Be Cleveland Topic

The Cleveland Guidance Center is offering a symposium on Emotional Problems of Children on Wednesday, April 26, at the Cleveland-Sheraton Hotel. The symposium coincides with the 42nd annual meeting of the center.

For the afternoon session beginning at 2:00 P. M., the following speakers and topics will be presented:

Sally Provence, M. D., director, Child Development Unit, Yale University Child Study Center — "Emotional Deprivation in Children."

Dane G. Prugh, M. D., professor of psychiatry and pediatrics, University of Colorado Medical Center — "Children's Reactions to Hospitalization."

Douglas Bond, M. D., professor of psychiatry, Western Reserve University School of Medicine, will be moderator of a panel discussion on the foregoing topics.

Following dinner, Spyros Doxiadis, M. D., chairman, Queen Anna-Maria Institute of Child Health, Athens, Greece, will speak on the topic, "Metara — An Experiment in Infant Rearing."

Reservations may be made with the Cleveland Guidance Center, Inc., 2525 East 22nd Street, Cleveland 44115.

New Members . . .

Following are names of new members of the Ohio State Medical Association certified to the Headquarters Office during January. List shows name of physician, county, and city in which he is practicing, or temporary addresses for those taking graduate work.

Hamilton

Robert A. Helton, Cincinnati
John J. Jager,
Newport, Kentucky
Earl F. Jordan, Cincinnati
Maria E. Pincho, Cincinnati
Ivan W. Rosen, Cincinnati
Kenneth W. Rowe, Jr.,
Cincinnati
Carl J. Schmidt, Cincinnati

Lorain

Rupert O. Clark, Oberlin

Lucas

James F. Gorman,
San Francisco, Calif.

Stark

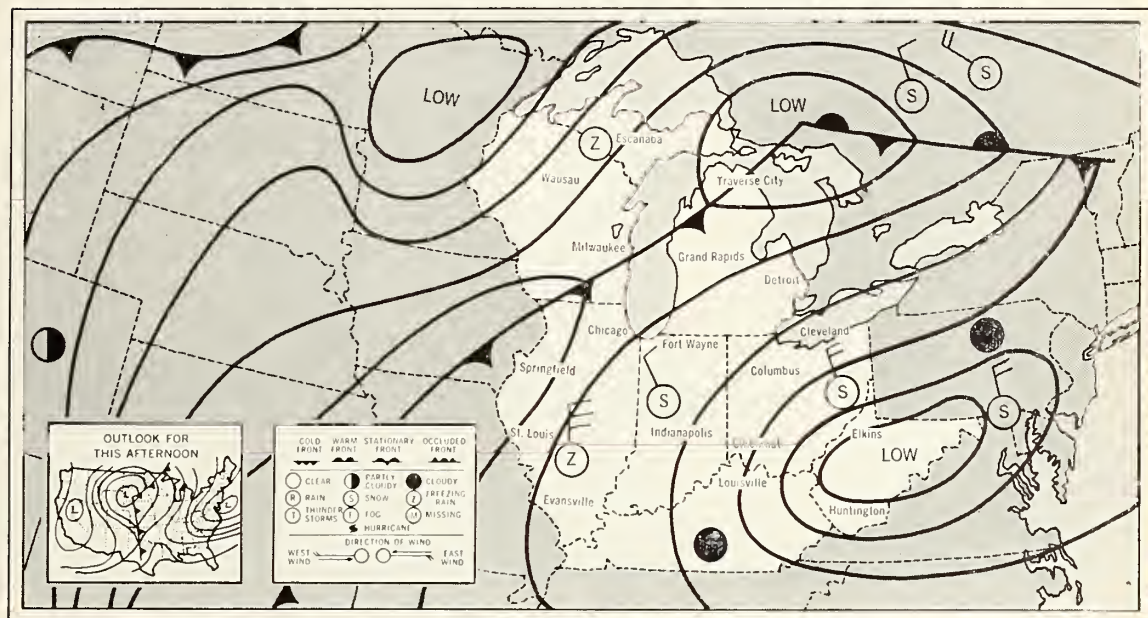
George J. Korte, Canton
Daniel L. Oberer, East Sparta
Tetsuo Tatsumi, Canton

The Ohio State University College of Medicine has been awarded a \$230,000 five-year grant renewal from the National Institutes of Health to support a training program in the Department of Obstetrics and Gynecology. According to Dr. John C. Ullery, department chairman, the training program, funded by the National Advisory Arthritis and Metabolic Diseases Council, prepares resident physicians for careers in academic medicine.

The Ohio State University Medical Center recently announced the start of a series of free classes for expectant parents.

REGIONAL WEATHER FORECAST

Severe Snow Storms, Strong Winds and Bitter Cold Followed by Cough, Stuffed and Runny Noses and Aches and Pains.



Tussagesic breaks up coughs, quickly clears stuffed and runny noses and relieves aches and pains. Provide coverage of the tough cold for up to 24 hours with just a single timed-release tablet dosed morning, midafternoon and at bedtime.

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timed-release tablet contains:

Triaminic®	50 mg.
(phenylpropanolamine hydrochloride 25 mg., pheniramine maleate 12.5 mg., pyrilamine maleate 12.5 mg.)	
Dextromethorphan hydrobromide	30 mg.
Terpin hydrate	180 mg.
Acetaminophen	325 mg.

Dosage: Adults—1 tablet, swallowed whole to preserve timed-release feature, in morning, midafternoon and at bedtime. **Side effects:** Occasional drowsiness, blurred vision, cardiac palpitations, flushing, dizziness, nervousness or gastrointestinal upsets. **Precautions:** The patient should be advised not to drive a car or operate dangerous machinery if drowsiness occurs. Use with caution in patients with hypertension, heart disease, diabetes or thyrotoxicosis.

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State Medical Board of Ohio - 1967



Above are the current members of the State Medical Board of Ohio, with the executive secretary.

Seated, from left: W. T. Washam, M.D., Columbus, Executive Secretary; John D. Brumbaugh, M.D., Akron; Mervin F. Steves, M.D., Cincinnati, President-Elect; D. A. Macedonia, M.D., Steubenville, President.

Standing: Henry A. Crawford, M.D., Cleveland; Lloyd R. Evans, M.D., Columbus; James O. Watson, D.O., Columbus; Ralph K. Ramsayer, M.D., Canton; and Frederick T. Merchant, M.D., Marion.

Western Reserve Researchers Get Substantial Grants

Research grants totaling nearly \$1 million for studies of physical medicine and hospital automation have been awarded to two doctors at Highland View Hospital, Western Reserve University in Cleveland.

The grants were awarded by the Vocational Rehabilitation Administration of the U. S. Department of Health, Education, and Welfare and the National Institutes of Health.

Dr. Charles Long, acting director of the Department of Physical Medicine and Rehabilitation at Highland View Hospital and an associate professor at WRU, received \$325,000 from the VRA and \$68,000 from the NIH.

The money will be used to continue research projects aimed at improving mobility and rehabilitation of paralyzed patients.

A VRA grant for \$578,000 went to Dr. Olgierd Lindan, chief of the metabolic ward of the hospital's

Internal Medicine and an associate professor at WRU and Case Institute of Technology.

Dr. Long's grants are for a period of three years. Dr. Lindan's grant is for five years.

AMA Sponsors Environmental Health Program in New York City

Learning to live in our environment without spoiling it by pollution will be the subject of a three-day scientific meeting in New York City April 24-26 at the Americana Hotel.

Sponsored by the American Medical Association, the National Congress on Environmental Health Management will be an assembly of major scientific and health authorities who are concerned with our growing population's management of air, water, and other irreplaceable environmental resources.

Organizations cooperating in the meeting are the Medical Society of the State of New York, the New York State Action for Clean Air Committee and the New York State Health Department.

GENERAL PRACTICE OF MEDICINE

By ROBERT L. REINHART, M.D.,

President, Central Ohio Academy of General Practice

WELCOME to another year of general practice! Or family practice, as the Ad Hoc Committee calls it, or primary physicianship, as Dr. Millis would say. But I say: Dodos of the future, arise! Our demise has been widely anticipated and reported, but *we ain't down yet*.

What are we doing here? We are now in the minority. Thirty-three per cent of practicing physicians say they are GP's. But — we still represent the largest single group of practitioners. We see 46 per cent of all patients seen; do 41 per cent of all deliveries; see 68 per cent of all patients in towns of less than 10,000 population; care for 41 per cent of all children under 10; write 45 per cent of all drug prescriptions; do 33 per cent of all hospital visits; 35 per cent of all surgery, and . . . 63 per cent of all home visits.

In our individual practices, we see an average of 7,660 patients per year, 38 per cent more than the average of all other MD's. We see more of all diseases than any other group of physicians, except for disorders of the nervous system, mental disease, and neoplasms. We see 65 per cent of all metabolic diseases; 61 per cent of all respiratory diseases; 58 per cent of blood and hematopoietic diseases; 54 per cent of infections; 54 per cent of disorders of bone and muscle; 52 per cent of circulatory diseases; and 51 per cent of all accidents and injuries.

Whence the Challenges?

We see 41 per cent of all conditions without sickness, such as immunizations, prenatal care, and routine examinations. These constitute 18 per cent of our practice — our largest single item, or about 1,361 visits a year. Respiratory disorders account for 1,202 visits a year, and circulatory disorders 874 per year.

With all this evidence that we are more efficient, and that we are appreciated and sought out by our patients, why then are we worried? We fear that we will lose the esteem of our patients, lose income, hospital privileges, and political power in medicine. We fear, that as our ranks are not replenished by young physicians, that we are a dying specialty.

But who challenges us?

Our most formidable opponent is the government of socialism. For the purpose of expanding and

consolidating power, the philosophy of the "rights" of the many at the expense of the excellence of the few, the false altruism of self-sacrifice for social welfare, the "Fifth Freedom" as the "RIGHT" to freedom from disease, whether the individual is willing to contribute to his own salvation or not, is being sold to the public. "You've got to keep check on these unscrupulous doctors, or they will pawn off second-class health on you." "Doctor, are you SURE? I read in the *Reader's Digest* that . . ." This is the philosophy that our government is foisting on the unsuspecting public.

The University Establishment challenges us. The universities have sold out to the government in return for "research grants." Personal power, money, and prestige reward the man who brings in the best research grant, and personal promotion as well. We don't have the money, or the prospects of getting the money, to compete with this.

To some extent, the public challenges us. For years they have been told that individual achievement is evil, that the rich man is bad. Rather all should strive to "raise the level of the masses." But if the individual gives up striving or competing, then he will starve unless all others are forced to give up competing. The last stronghold of individual enterprise is the medical profession, and more specifically, the private practice of personal medical care. This is being eroded by the "Right" to "Medicare," the "Right" to freedom from illness. The worst thing we can do is let our patients lose the sense of personal service in what we do, for then they will lose their last contact with individualism.

We, ourselves, challenge us. We do this when we say "I'm JUST a GP." When we modestly shy from publicity for our accomplishments. When we guiltily play down our income or standard of living to patients, whining that we "worked hard" for it or we "spent a long time in school," instead of saying, "My services are special and worthwhile. They are uniquely mine, and I deserve the reward for them."

Where Responsibility Lies

How can we resist these challenges? The government believes that it can do a better job in Preventive care in hospital-centered practice, doing complete physicals, immunizations and preschool checkups. Or, if the government doesn't really believe this,

This is the text of an address delivered by Dr. Reinhart before the Central Ohio Academy of General Practice on January 21, 1967.

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pH—values are read numerically in the essential range of pH 5 to pH 9.

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Glucose—provides a "Yes-or-No" answer for urine "sugar spill."

Ketones—detects ketone bodies in urine—both acetoacetic acid and acetone. Reacts with as little as 5 to 10 mg. % of acetoacetic acid.

Occult Blood—specific test for intact red cells, hemoglobin or myoglobin. Results are read as negative, small, moderate or large amounts.

Now a Clear Reagent Strip of Firm Construction

...facilitates handling during testing procedure. Excellent color contrast made possible by the clear plastic strip, together with the clearly defined color charts provided, permits precise, reproducible colorimetric readings in all 5 test areas. A more definitive interpretation of uro-analytical facts is made possible.

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they are selling the idea to the public in exchange for votes. This is the largest single item in our practice. We know that a complete physical by us, in the context of 10 to 20 years of care for the same family, is worth infinitely more than a physical by the greatest physical diagnostician, isolated from the family and recorded in the outpatient clinic records. We know that our patients would not tolerate impersonal postoffice care, such as they would be given, like military sick call. Personal care for a patient by a doctor is directly tied to personal responsibility. Personal responsibility results most readily when the doctor must earn his fee by serving the patient. Physicians on annual salaries, or in the employ of government, cannot and do not have this feeling for their patients. Patients are not and do not want to be "cases." We must update, streamline, compete pricewise, and remain personal, to sell our patients and make them cognizant of this ideal.

Respiratory and circulatory disorders constitute the remaining portion of the major 45 per cent of our practices. Availability is our primary asset. We are the patient's advocate. We select for him the best in medical care, either through ourselves or through our referrals. We know the ropes, and how to get him into and out of the hands of specialists and hospitals fast, and we hope, economically and painlessly. We are the "Chairmen of the Board" of special technicians, and should not hesitate to exercise our power to veto and direct when we see it to be in the patient's interest. And, our long term follow up gives us better knowledge of epidemiology and natural history of disease, than any limited practitioner.

General Practice — A Goal

We must attract young men to our specialty on its merits. We want not the leftovers from specialty residencies, but the best, quickest, most compassionate, talkative, protesting, but *thinking* young men. Core programs for residency and postgraduate training are fine, but by then it is too late to interest medical students in general practice. The medical school subspecialists have had four years to indoctrinate them by then. We must start with the freshmen, and in the medical school. Programs of preceptor-like social sciences in the freshman year, with limited but increasing patient contact in an outpatient and home-visit situation, is where we must begin to work.

How do we meet these challenges? The future of the GP lies in being a personal, knowledgeable, purveyor of the best in medical service. He must be the patient's advocate, and a broker of medical services. He does not and should not attempt to outdo the technicians in their techniques, unless willing to devote equal time and effort to perfect his own technique.

We must continue to be efficient, available, compassionate and skillful. We can continue to enjoy our practices by enjoying our patients. We can and should remain experts on the difficult arts of office practice: presumptive diagnosis of viral diseases in the population; the skilled art of listening and caring about our friends troubles; the technique of *not* giving antibiotics; the protection from quackery; the promotion of good preventive medicine.

Then, we will continue to have the pride of our achievements, the satisfaction of being appreciated and needed, and the joy of our individuality and independence.

Agreement Reached on Operation Of Tuberculosis Hospital

Trustees of Ohio State University recently ratified an agreement with the Ohio Department of Health under which the university will operate the Ohio Tuberculosis Hospital as an agency of the College of Medicine.

The hospital is situated on the campus in the Medical Center area.

Under terms of the agreement, approved by the Ohio Attorney General, the university will provide care for tuberculosis patients admitted by the state director of health to the University Hospital and housed in the Ohio Tuberculosis Hospital.

The agreement provides also that:

The medical superintendent of the TB Hospital will be appointed by the state director of health and will report to him on administrative matters. Administration of the building and services will be handled by the administrator of University Hospitals and his staff, including not only day-to-day operation, but budgetary and fiscal matters, building, and other activities.

Admissions will be limited by admission policies of the director of health so that cost of providing care does not exceed the budget of the department for the operation of the hospital.

The College of Medicine may use available facilities of the TB Hospital to continue research and educational programs and to institute new and more intensive programs provided such programs do not interfere with providing adequate care and treatment of TB patients.

Dr. Austin Smith is the new vice-chairman of the Board of Directors of Parke, Davis & Company, Detroit-based pharmaceutical manufacturing company, and its chief executive officer. Dr. Smith is former editor of the *Journal of the American Medical Association*, and former president of the Pharmaceutical Manufacturers Association.

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for multiple contraceptive action that has produced a record of unexcelled effectiveness

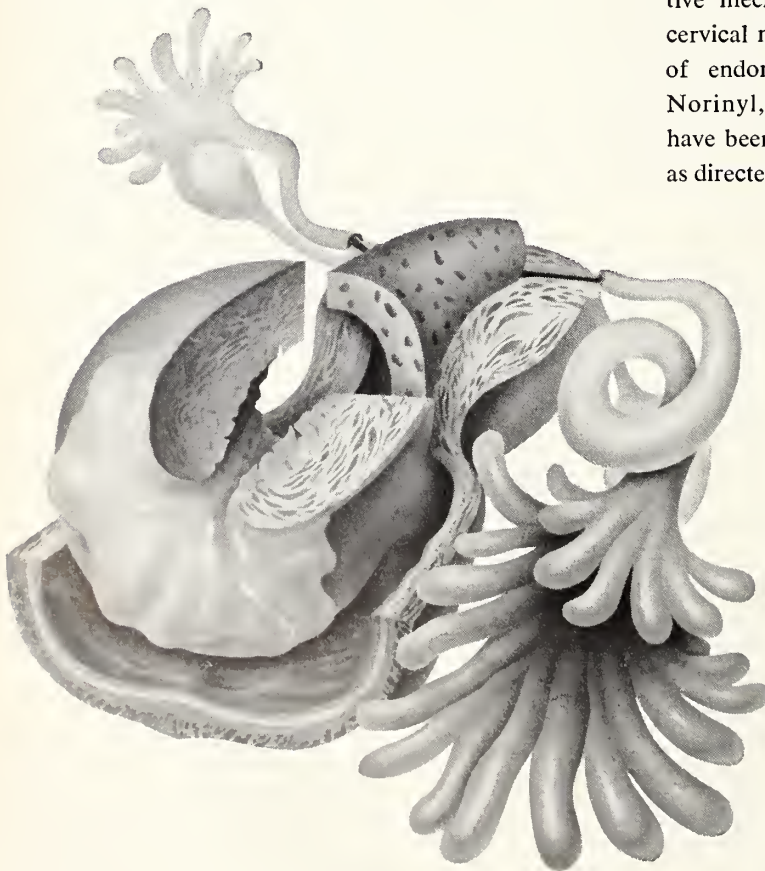
**inhibition of ovulation by means of
2 time-proved hormonal agents**

**production of a cervical mucus hostile to
sperm motility and vitality**

**creation of an endometrium unreceptive
to egg implantation**

no unplanned pregnancies

Norinyl provides multiple action for maximum assurance of success. It does not depend on ovulation inhibition alone for contraceptive effectiveness. The mechanism of action of combined hormonal therapy results in ovulation inhibition reinforced by other protective mechanisms, including a hostile cervical mucus¹⁻¹³ and an acceleration of endometrial changes.^{1-3,7-16} With Norinyl, no unplanned pregnancies have been reported to date when used as directed.



plus important supportive benefits that help her through those critical early months of oral contraception

low incidence of side effects

Low incidence of BTB and spotting, nausea and amenorrhea tends to minimize side effect problems and increases patient cooperation.

no confusion about dosage

An unbreakable "confusionproof" package makes it easy to adhere to prescribed dosage schedule: individually sealed tablets numbered from 1 through 20 *plus* monthly calendar record enables patient to double-check dosage intake by day and corresponding tablet number.



Contraindications: Thrombophlebitis or pulmonary embolism (current or past). Existing evidence does not support a causal relationship between use of Norinyl and development of thromboembolism. While a study which was conducted does not resolve definitively the possible etiologic relationship between progestational agents and intravascular clotting, it tends to con-

firm the findings of the Ad Hoc Advisory Committee appointed by the Food and Drug Administration to review this possibility. Cardiac, renal or hepatic dysfunction. Carcinoma of the breast or genital tract. Patients with a history of psychic depression should be carefully studied and the drug discontinued if depression recurs to marked degree. Patients with a history of cerebral vascular accident.

Warning: Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn.

Precautions: By May 1963, experience with norethindrone 2 mg.—mestranol 0.1 mg. had extended over 24 months. Through miscalculation, omission or error in taking the recommended dosage of Norinyl, pregnancy may result. If regular menses fail to appear and treatment schedule has not been adhered to, or if patient misses two menstrual periods, possibility of pregnancy should be resolved before resuming Norinyl. If pregnancy is established, Norinyl should be discontinued during period of gestation since virilization of the female fetus has been reported with oral use of progestational agents or estrogen. When lactation is desired, withhold Norinyl until nursing needs are established. Existing uterine fibroids may increase in size. In metabolic or endocrine disorders, careful clinical preevaluation is indicated. A few patients without evidence of hyperthyroidism had elevated serum protein-bound iodine levels, which in the light of present knowledge, does not necessarily imply hyperthyroidism. Protein-bound iodine increased following estrogen administration. Bromsulphalein retention has occurred in up to 25% of patients without evidence of hepatic dysfunction. Studies from 24-hour urine collections have shown an increase in aldosterone and 17-

ketosteroids and decrease in 17-hydroxycorticoid levels. Thus, Norinyl should be discontinued prior to and during thyroid, liver or adrenal function tests. Because progestational agents may cause fluid retention, conditions such as epilepsy, migraine and asthma require careful observation. Thus far no deleterious effect on pituitary, ovarian or adrenal function has been noted; however, long-range possible effect on these and other organs must await more prolonged observation. Norinyl should be used with caution in patients with bone, renal or any disease involving calcium or phosphorus metabolism. **Side Effects:** Intermenstrual bleeding; amenorrhea; symptoms resembling early pregnancy, such as nausea, breast engorgement or enlargement, chloasma and minor degree of fluid retention (if these should occur and patient has not strictly adhered to medication plan, she should be tested for pregnancy); weight gain; subjective complaints such as headache, dizziness, nervousness, irritability; in a few patients libido was increased. In a total of 3,090 patients, 2.2% discontinued medication because of nausea.

NOTE: See sections on contraindications and precautions for possible side effects on other organ systems.

Dosage and Administration: One Norinyl tablet orally for 20 days, commencing on day 5 through and including day 24 of the menstrual cycle. (Day 1 is the first day of menstrual bleeding.)

Availability: Dispensers of 20 and 60 tablets; bottles of 100.

References: 1. Council on Drugs, JAMA 187:664 (Feb. 29) 1964. 2. Bravans, F. E.: Canad Med Ass J 92:287 (Feb. 6) 1965. 3. Goldzieher, J. W.: Med Clin N Amer 48:529 (Mar.) 1964. 4. Cohen, M. R.: Paper presented at Symposium on Low-Dosage Oral Contraception, Palo Alto, Calif., July 15, 1965. Reported in Med Sci 16:26 (Nov.) 1965. 5. Hammond, D. O.: Ibid. 6. Rice-Wray, E., Goldzieher, J. W., and Aranda-Rosell, A.: Fertil Steril 14:402 (Jul.-Aug.) 1963. 7. Goldzieher, J. W., Moses, L. E., and Ellis, L. T.: JAMA 180:359 (May 5) 1962. 8. Kempers, R. D.: GP 29:88 (Jan.) 1964. 9. Tyler, E. T.: JAMA 187:562 (Feb. 22) 1964. 10. Rudel, H. W., Martinez-Manautou, J., and Maqueo-Topete, M.: Fertil Steril 16:158 (Mar.-Apr.) 1965. 11. Flowers, C. E., Jr.: N Carolina Med J 25:139 (Apr.) 1964. 12. Goldzieher, J. W.: Appl Ther 6:503 (June) 1964. 13. The Control of Fertility. Report adopted by the Committee on Human Reproduction of the American Medical Association. JAMA 194:462 (Oct. 25) 1965. 14. Flowers, C. E., Jr.: JAMA 188:1115 (June 29) 1964. 15. Merritt, R. I.: Appl Ther 6:427 (May) 1964. 16. Newland, D. O.: Paper presented at Symposium on Low-Dosage Oral Contraception, Palo Alto, Calif., July 15, 1965. Reported in Med Sci 16:26 (Nov.) 1965.

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Death Takes Physicians Prominent in Ohio Medical Organization Work

George John Hamwi, M. D., Columbus; outstanding authority in the field of endocrinology and metabolism, medical educator, and Past President of the Ohio State Medical Association, died on February 14 at the age of 52.

A native of New York City, Dr. Hamwi attended Columbia University for three years and received his bachelor's degree from the American University of Beirut. He remained in Beirut and received his medical degree from the same university in 1940. This action followed a tradition of the family since his father and his grandfather before him received degrees from the same university.



Dr. Hamwi

During World War II, he served as flight surgeon with the Navy and attained the rank of lieutenant colonel. He first came to Ohio State University as a resident following the war and received a Master of Science degree. Additional residency work followed in New York and he returned to OSU to become associated with the Section of Endocrinology and Metabolism. He held a full professorship in the university and for a number of years headed the Clinical Metabolic Research Unit where he directed a complex type of investigation delving into origins of a broad spectrum of diseases.

Dr. Hamwi's interest in medical organization work was indicated by his participation in more than a score of professional groups dedicated to the advancement of medicine and health. He was elected Treasurer of the Ohio State Medical Association in 1956; was named President-Elect in 1961, and was installed as President in 1962. He previously served as chairman of the OSMA Committee on Scientific and Educational Exhibits; was a director of Ohio Medical Indemnity; and was chairman of the American Medical Association Council on Foods and Nutrition.

Dr. Hamwi was a diplomate of the American Board of Internal Medicine, a Fellow of the American College of Physicians, member of the American Geriatrics Society, the Endocrine Society, Central

Society for Clinical Research, the Association of American Medical Colleges, Ohio Academy of Science, American Association for the Advancement of Science, American Federation of Clinical Research, New York Academy of Sciences, American Goiter Society, Central Ohio Heart Association, and the American Cancer Society. He was also affiliated with the Royal Society of Medicine in London.

A prolific writer, he contributed clinical articles to *The Ohio State Medical Journal* and to numerous national and international publications. Survivors include his widow, three sons, his mother, a brother, and two sisters.

Carl Seymour Mundy, M. D., Toledo; Eclectic Medical College, Cincinnati, 1913; former member of The Council of the Ohio State Medical Association, outstanding physician practicing in the field of internal medicine, and long associated with the Ohio Medical Indemnity which he helped to establish, died at the age of 77 on February 6.

Dr. Mundy was born in Forest, Ohio, the son of a physician. He began his practice in Toledo in 1915, and three years later entered the Army Medical Corps for a tour of active duty during World



Dr. Mundy

War I. Long interested in medical organization work, he was active in affairs of the Academy of Medicine of Toledo and Lucas County and became its president in 1939. In 1947 he was elected as a member of The Council of OSMA and served as Council of the Fourth District until 1953. He was later elected a Delegate to the American Medical Association and served in that

capacity for a number of years.

Dr. Mundy was appointed to the OSMA Committee on Medical Service Plans in 1944 and was instrumental in organization of Ohio Medical Indemnity, the OSMA-sponsored Blue Shield Plan in Ohio. He worked closely with OMI during its period of phenomenal growth and development, serving on

the board of directors for many years, and as vice-president and chairman of the executive committee.

His background work in committee activities was outstanding. While on The Council he served on the Auditing and Appropriations Committee, the committee that advises The Council on Association's financial matters. He was long a member and chairman of the OSMA Committee on Rural Health, the group responsible for organizing the OSMA Rural Medical Scholarship program, the orientation lectures for students in Ohio medical schools, and other programs to encourage physicians to settle in non-metropolitan areas. He also served for many years on the AMA Committee on Rural Health. In addition to his memberships in the OSMA and the AMA, he was a Fellow of the American College of Physicians, and diplomate of the American Board of Internal Medicine. His widow and a daughter survives.

Clarence George Bozman, M. D., Newark; Ohio State University College of Medicine, 1915; aged 74; died January 20; member of the Ohio State Medical Association and the American Medical Association. A practitioner in Licking County for virtually all of his professional career, Dr. Bozman first located his office in the Hebron area and moved to Newark in 1927. His specialty was pediatrics. He was a member of the Methodist Church and several Masonic bodies. Surviving are his widow, a daughter and a son.

Albert Leonard Braunstein, M. D., New Orleans; University of Cincinnati College of Medicine, 1937; aged 55; died October 11. Dr. Braunstein left Ohio shortly after receiving his medical degree in Cincinnati.

Aloysius William Burek, M. D., Gainesville, Fla.; University of Wisconsin Medical School, 1937; aged 57; died September 6. A former practitioner in Wausau, Wisconsin, Dr. Burek was in Ohio for a short time before moving to Florida.

Malcolm Orr Cook, M. D., Sun City, Florida; University of Cincinnati College of Medicine, 1923; aged 68; died January 15; former member of the Ohio State Medical Association and the American Medical Association; Fellow of the American College of Surgeons. A former practitioner in Hamilton, Dr. Cook moved to Jackson, Mich., about 15 years ago and had only recently made his home in Florida. In Hamilton he was active in community affairs and was associated in the Oxford area where he was born. A veteran of both World Wars, he was a member of the American Legion. Other affiliations include membership in the Masonic Lodge, the Elks Lodge, and the Presbyterian Church. Survivors include his widow, two sons, and a daughter.

William Warren Dangeleisen, M. D., Cleveland; Eclectic Medical College of Ohio, 1920; aged 74; died January 7; member of the Ohio State Medical Association and the American Psychiatric Association.

Dr. Dangeleisen was a resident of Cleveland for most of his life and took residency training at the Cleveland State Hospital before he entered private practice in psychiatry. He was a member of the Catholic Church and the Knights of Columbus.

Robert Joel Dial, M. D., Cleveland; Yale University School of Medicine, 1925; aged 66; died January 19; member of the Ohio State Medical Association, the American Medical Association, and the American Academy of General Practice. Dr. Dial practiced for some 40 years in the West Side area of Cleveland. He is survived by his widow, two sons, a daughter, and a brother, Dr. Donald E. Dial, of Lakewood.

Howard C. Eddy, M. D., Mercer Island, Wash.; Western Reserve University School of Medicine, 1929; aged 62; died January 23; former member of the Ohio State Medical Association; member of the American Academy of General Practice. A physician in the Cleveland area for many years, Dr. Eddy practiced there until 1941. He was a veteran of World War II. Surviving are his widow, three sons, and a sister.

William Daniel Hickerson, M. D., Hendersonville, N. C.; University of Virginia School of Medicine, 1926; aged 70; died January 17; former member of the Ohio State Medical Association. Dr. Hickerson retired in 1961 after a number of years as medical director of the Union Central Life Insurance Company in Cincinnati, and former superintendent of the Dunham Hospital in Cincinnati. He was a veteran of World War I. Surviving are his widow, his son-in-law and daughter, Dr. and Mrs. Paul N. Jolly, of Cincinnati; also two sisters and a brother.

Charles Roland Kistler, M. D., Columbus; Ohio State University College of Medicine, 1961; aged 31; died January 18. After taking his internship in Cleveland and residency training in Columbus, Dr. Kistler entered active duty in the Navy in 1965. He held the rank of lieutenant commander, and was stationed at Camp Pendleton, Calif. Survivors include his widow, a daughter, and three sons; also his maternal grandmother and a sister.

Adolfs Karlis Lazdins, M. D., Cleveland; Imperial University of Moscow Faculty of Medicine, 1914; aged 78; died November 3; member of the Ohio State Medical Association and the American Medical Association. A native of Latvia and educated in Europe, Dr. Lazdins practiced in Europe for many years. He was licensed in Ohio in 1953 and his practice in Cleveland was in the field of obstetrics and gynecology.

William Bertram Mansur, M. D., Dayton; Cleveland Pulte Medical College, 1913; aged 78; died January 22; member of the Ohio State Medical Association and the American Medical Association. Dr. Mansur's practice in the Dayton area covered a period of 53 years. He was a member of the American Legion, having served in a medical detachment over-

seas during World War I. Other affiliations include membership in the Methodist Church and the Masonic Lodge. Survivors include his widow, three daughters, and a sister.

Joseph Michael Ranz, M. D., Youngstown; Miami Medical College, Cincinnati, 1908; aged 82; died December 30; member of the Ohio State Medical Association and the American Medical Association. Dr. Ranz was a physician of long standing in Youngstown where he specialized in surgery. He was active in medical organization work in the area and was president of the Mahoning County Medical Society in 1918.

A. Sophie Rogers, M. D., Columbus; Ohio State University College of Medicine, 1930; aged 75; died January 10; member of the Ohio State Medical Association, the American Medical Association, and the American Academy of General Practice. Dr. Rogers was a physician of long standing in Columbus and known also for her civic and philanthropic activities. He held both M. D. and Ph. D. degrees, and for many years was on the faculty of Ohio State University. She was long a member and at one time president of the Florence Crittenton Home board of trustees. She was also a founder of the Peter Pan Playhouse, a nursery school. Other affiliations included membership in the Altrusa Club, the Clintonville Women's Club, and the Methodist Church. A brother survives.

Herman Moses Rogoff, M. D., Akron; Rush Medical College, 1900; aged 86; died January 27; former member of the Ohio State Medical Association and the American Medical Association. A practitioner of long standing in Akron, Dr. Rogoff was living in retirement in recent years. Survivors include a daughter and two sons, one of whom is Dr. Robert Rogoff.

Franklin I. Shroyer, M. D., Troy; Ohio State University College of Medicine, 1910; aged 78; died January 7; former member of the Ohio State Medical

Association and the American Medical Association. Dr. Shroyer was living in semiretirement on his farm near Troy, after a long practice in Dayton where he specialized in gynecology and surgery. He was the author of a medical text and numerous articles. In 1956 he was named to Fellowship in the New York Academy of Sciences. Among survivors are his widow, three sons, a daughter, a brother, and a sister.

Robert Lincoln Thomas, Kinsman; Western Reserve University School of Medicine, 1912; aged 81; died January 22; member of the Ohio State Medical Association and the American Medical Association. Dr. Thomas began his practice in Cleveland and moved to Kinsman in 1930, where he engaged in private practice and for about 12 years was Trumbull County health commissioner. Among affiliations, he was a member of several Masonic bodies. Surviving are two daughters and two sons.

WHAT TO WRITE FOR

State Definitions of Live Births, Fetal Deaths, and Gestation Periods at Which Fetal Deaths are Registered — A copy of this publication, revised in May, 1966, may be obtained by writing Office of Information and Publications, Department of Health, Education, and Welfare, Public Health Service, Washington, D. C. 20201.

* * *

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Woman's Auxiliary Highlights...

By MRS. S. L. MELTZER, Chairman, Publicity Committee
2442 Dorman Drive, Portsmouth 45662

WASAMA . . . an intriguing name for an intriguing group of young women. WASAMA has, I think, the unmistakable cadence of Indian words so familiar to Ohioans. Actually, of course, WASAMA stands for the Woman's Auxiliary to the Student American Medical Association. In short—the doctors' wives of the future.

It was in 1957 that a handful of members of the national auxiliary, along with a few student wives and the staff of Student AMA, founded WASAMA. It had a two-fold purpose: To prepare these young women for their future role as wives of doctors in the community; and to bring such wives and their families together with other medical families and medical groups for their mutual benefit.

Today there are some 5,000 members in 53 chapters. For geographic feasibility, the national organization is divided into seven regions. Our doctors' wives' auxiliary is very active and very interested on the local, regional, and national levels. Here in Ohio, Mrs. N. M. Reiff, a past state president and member of the current state board, is our liaison officer with WASAMA, working diligently and wisely with the local chapters. I might add that membership is open to all student, intern, and resident wives. Dues are mighty nominal—one dollar per year per member.

The group even operates a National Housing Service in 30 cities. Through this service, any member may request specific information concerning whatever type of housing she and her family desire in the area to which they are moving. Questions frequently asked include: rent, size, pets, furnished possibilities, distance to the hospital, shopping centers, churches, schools, etc. This service found homes for 300 medical students, interns, and residents last year. Programs and project files contain a multitude of time-tested ideas for monthly programs, fund-raising projects, community service projects, social events, and other general chapter activities. This file has been established by each chapter which continually sends in to the national office its best programs for all to share.

Recently, the *Cincinnati Post and Times-Star* featured a delightful story on the local WASAMA chapter. The headline read "Their Trick of Sharing Makes Entertaining Easy for Medical Wife." The article described the various and unique ways of plucking parties out of thin air—the juggling of

pennies into patterns of creative magic. In other words, WASAMA's bag of tricks is filled with ideas for entertaining on a shoestring.

Mrs. Kenneth Stoutenborough, the local project chairman, explained that, except for two yearly dances, married students tend to break up into "small, happy groups." There have been parties with a French theme (decorations were paper Eiffel Towers—the room was bathed in candlelight—on the tables were wine bottles dripped with candlewax—each couple brought a Gouda or hickory smoked cheese, a salami or bologna sausage—the hosts "sponsored" the wine). Then there was Mrs. Stoutenborough's own "come as you are" party which was a hilarious success. One popular pastime is a penny ride. Several couples go driving, flipping a coin at each crossroad—heads they turn left, tails they go right. There seems to be no end to the original and clever ideas that come from these incredibly versatile WASAMA's. In Cincinnati, the group's particular project is the Children's Home. In February, the young women sponsored an etiquette program to advise older girls how to dress and how to behave at a business interview. There was also an "assembly line" sewing party and something made as a gift for each girl. Here's our printed orchid to the wonderful future doctors' wives of America!

Around the State

Columbiana County auxiliary came up with a novel Christmas party event to which members of the county medical society were invited—a "Playboy Club," of all things! Invitations were in the form of a cardboard key. Each auxiliary member wore a bunny-ears headband, and the men received door-prize numbers on "pink ears." The head table featured an attractive Christmas arrangement, in the middle of which were two large stuffed bunnies dressed in the evening attire of Playboy bunnies. Table favors, made by the committee, were black-felt bunny heads with pink ears which covered apothecary jars filled with hard candies. Cocktail stirrers had bunny head tops. Bunny balloons with paper ears were released about the room as a grand finale. Committee members sold orchids and cigarettes for the benefit of AMA-ERF and came up with an almost unbelievable profit of \$459.00. The "magic"

of that was due to the outstanding cooperation of the Riverview Orchid Company of East Liverpool who donated the orchids and the Culp Drug Store of Wellsville who donated the cigarettes.

Ten door prizes were given in the bunny tradition — bunny playing cards, bunny lighters, Playboy calendars and champagne. The soloist of the evening was Barbara Banfield who was accompanied by Ray Lautzenheiser. Group singing was led by Dr. Janis Lauva. Dr. William Horger operated the slide projector that screened the words of the various songs. Dr. William Gilmore played the role of Santa and "brought forth" bunnies Peg Turner, Irene Jackson, Geneva Banfield, and Pat Sinclair who jumped from behind large, gift-wrapped boxes and sang and danced. Mrs. Richard Bonistalli, president of the Columbiana group, extended eloquent thanks to these creative committee members: Mrs. K. W. Turner, chairman; Mrs. C. A. Gerace, Cochairman; Mrs. H. F. Banfield, Mrs. William Banfield, Mrs. William J. Horger, Mrs. J. Fraser Jackson, Mrs. Janis Lauva, Mrs. J. M. Nedelkoff and Mrs. Stephen G. Sinclair.

The auxiliary's January meeting was a dinner at which one of its members, Mrs. R. M. Dunlap, reviewed the book "I Just Happened To Have Some Pictures" by Willie Snow Ethridge. Hostesses included: Mrs. Laslo Bujdosa, Mrs. R. V. Rankis, Mrs. Peter Cibula and Mrs. Wade Bacon.

Health Careers

There are fifty Health Careers Clubs in the Hamilton County area. Two representatives from each club comprise the Interclub council which meets four times a year and publishes three newsletters. At a recent meeting of the council, plans were finalized for the field trip to the William S. Merrell Company that had been arranged by the Hamilton County auxiliary for Saturday, January 21. The doctors' wives work very closely and zealously with these Health Careers Clubs throughout the year.

The January meeting of the Hamilton group was a luncheon at the Barkley House, Greater Cincinnati Airport, at which the speaker was the celebrated Mrs. Jerrie Mock, first aviatrix to solo around the world. Mrs. Mock studied aeronautical engineering, took flying lessons, managed an airport and worked as a mechanic before covering 22,800 miles and breaking seven world records on her round-the-world flight. Mrs. W. P. Mazur and Mrs. Donald E. Gunderson planned the afternoon program. Hospitality chairmen were Mrs. Charles H. Foertmeyer and Mrs. Carl G. Ruehlmann. Assisting in registration were Mrs. Jerome Giuseffi, Mrs. Donald Heuer, Mrs. James Poon, Mrs. Warren Strohmenger and Mrs. Merton F. Wilson. The benefit fashion show featuring fashions from Henry Harris of Cincinnati will be held March 21 at the Hofbrau House. Mrs. Don Aichholz is chairman of this special event.

Our Teen-Agers

Lucas County's program for the January luncheon was a panel discussion on "Our Teen-Agers — Their Team of Problem Solvers." The three Toledo women on the panel held the unique qualifications of being mothers of teen-agers, and having excellent training in testing and counseling young people. Mrs. Barbara McKellen is a school psychologist at thesylvania public schools. Mrs. Dorcas Hanson is a casework supervisor and referee in the Lucas County Court in the division of the Child Study Institute. Dr. Ruth Myers, clinical psychologist and assistant professor in the Department of Psychology, University of Toledo, is the wife of Dr. Richard Myers and an auxiliary member.

The discussions involved identification of present-day stresses, parental forces, problems of suicide, sexual indulgence, alcoholism, and depression. Mrs. James Roberts acted as moderator. Time was allotted for questions and a book list and pertinent materials were made available.

The Lucas group also had its annual "Morning Coffee Concerts" in January for the benefit of the Citizens' Day Care Program for School Children. Each morning during the week of January 9, a gracious hostess opened her home for a musicale and coffee. It was a wonderful opportunity for local residents to hear again outstanding Toledo musicians, a delightful way for auxiliary members to entertain friends and a profitable way of making money for a worthwhile project. Mrs. A. J. Kuehn served as chairman. Cochairmen were Mrs. James M. Diethelm and Mrs. John J. Tansey.

The Scioto County auxiliary held its February meeting at the Ohio Valley Gas Company where Betty Newton, home service adviser, presented a program on "Instant Entertaining." Such items as Tantalizing Chicken, Quick Italian Rice, Velvety Custard Pie, Cheese-Y Peach Cobbler, Dill Green Beans (I could go on and on) were prepared and cooked before the group — and later "tasted" (which, of course, was the best part!).

Also at this meeting, the nominating committee slate as presented by Mrs. Louis Chaboudy, chairman, was voted upon. These are the women who will take office at the May meeting: Mrs. Clyde Hurst, president; Mrs. William Daehler, president-elect; Mrs. Jerome Rini, vice-president; Mrs. Richard Villarreal, secretary; Mrs. Donald Appleton, treasurer; Mrs. James Scott, historian; and Mrs. Frank Gatti, elected member to the Board.

Headline News

The Tuscarawas County auxiliary is really coming up with Something Big in the way of a legislation program for its spring meeting, Wednesday evening, April 5. It will be presenting no less a personage than Dr. Edward R. Annis, of Miami, Florida, Past President of the American Medical Association

and well-known speaker and television personality. He will discuss "Where Are We? Where Are We Headed?" It is no small feat to get as speaker a man of Dr. Annis' stature and the Tuscarawas auxiliary is happily indebted to Dr. and Mrs. E. L. Miller of Dennison who are personal friends of Dr. Annis. All doctors and their wives from neighboring counties (or from any interested county) are cordially invited as are the general public, members of other professions, civic clubs, ministerial associations and so on. It should be a tremendous and informative program.

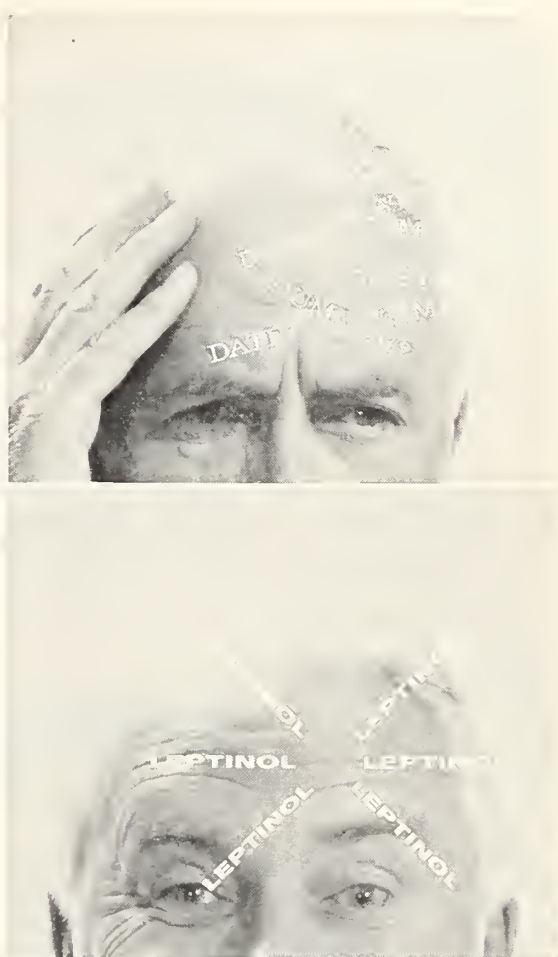
The group's December meeting was a Christmas party at the Reeves Hotel to which members of the county medical society were invited. Dr. R. J. Kuba, president, played Santa Claus and presented each one with a gift. There was also an appropriate verse for each doctor. And guess who the poet was? No less a charming somebody than our own Mary Louise Van Epps. (What a woman!) Dr. R. B. Giles entertained the group with a film he had made of Christmas, 1957 in the Union Hospital. Dr. James Zeller, incoming medical society president for 1966-67, was presented. Mrs. R. A. Wilson entertained with a program of songs and later led the group in the singing of Christmas Carols. The committee for the holiday event were Mrs. Van Epps, Mrs. C. R. Crawley, Mrs. E. C. Davis, and Mrs. James Zeller.

At the auxiliary's January meeting, Mrs. Van Epps who is local AMA-ERF chairman, reported that \$1900 had been raised to date. Isn't that a remarkable showing for one of our smaller auxiliaries? Shows what can be done when there's the will to do it . . . (Tuscarawas has been the recipient of national awards). Mental health featured the program of the first meeting of the new year with the presentation of the film "Beyond The Shadow." Named to the nominating committee at this meeting were Mrs. R. J. Kuba, chairman; Mrs. C. R. Crawley, and Mrs. Robert Hastedt. It was reported that 201 pounds of drugs have been donated to World Medical Relief. During the social hour, refreshments were served by Mrs. P. T. Doughten, Mrs. Burrell Russell, Mrs. J. R. Martin, Mrs. William Roche, Mrs. Tom Ogden and Mrs. F. F. Gonzales.

State Convention

It's certainly about time to mention the date—the week of May 14. Next month's issue of the *OSMA Journal* will carry information on this most important annual meeting. In the meantime, you might like to know this: Auxiliary headquarters and all Auxiliary sessions will be at the newly remodeled, attractively furnished Neil House in Columbus. (And it isn't any too early to be sending in your room reservation!)

for March, 1967



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One measure, of course, is reassurance. Another, adjunctive measure, is EQUANIL (meprobamate).

Over a decade of experience has shown that EQUANIL (meprobamate) is generally well tolerated as well as effective. Side effects are usually limited to transient drowsiness; serious, therapy-interrupting side effects are rare.

Cautions: Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use may result in dependence or habituation in susceptible persons—as ex-addicts, alcoholics, severe psychoneurotics. After prolonged high dosage, drug should be withdrawn gradually to avoid possibly severe withdrawal reactions including epileptiform seizures. Side effects include drowsiness and, rarely, allergic or idiosyncratic reactions. These reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Mild reactions are characterized by urticarial or erythematous maculopapular rash. Acute non-thrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever have been reported. Meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Warn patients of possible reduced alcohol tolerance. Should drowsiness, ataxia, or visual disturbances occur, dose

should be reduced. If symptoms persist, patients should not operate vehicles or dangerous machinery. A few cases of leukopenia, usually transient, have been reported following prolonged dosage. Other blood dyscrasias—aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia—have occurred rarely, almost always in the presence of known toxic agents. One fatal case of bullous dermatitis following intermittent use of meprobamate with prednisolone has been reported. Prescribe very cautiously for patients with suicidal tendencies. Suicidal attempts should be treated with immediate gastric lavage and appropriate supportive therapy.

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AMA Annual Convention...

The American Medical Association Is Scheduled To Meet In Atlantic City for Comprehensive Program, June 18-22

PATIENT CARE, from the standpoint of standard methods as well as research, will be one of four topics presented in general scientific sessions at this year's Annual Convention of the American Medical Association.

The Convention is to be held in Atlantic City June 18-22; the Scientific Program will be at Convention Hall, and nearby hotels, and the House of Delegates will meet at the Chalfonte-Haddon Hall Hotel.

The General Scientific Meetings are open to all physicians attending the Annual Convention.

Other General Scientific Meetings on this year's Annual Convention program will be on the subjects of: backache, healing, and sex.

In addition to the General Sessions, each of the 22 Scientific Sections will present programs. Many of the Section programs will, as in past years, be joint meetings of two or more Sections and, in some instances, a specialty society.

Specialty societies joining AMA Sections will include:

The American College of Chest Physicians, which will join the Section on Diseases of the Chest for a program.

The American College of Cardiology, which will join the Section on Internal Medicine in a session.

The Society for Investigative Dermatology, Inc., which will hold its meetings in conjunction with the Section on Dermatology.

Symposia

Symposia of interest to both the generalist and the specialist will be included in this year's Scientific Program.

A Symposium on Absorption and Storage of Iron will be presented as a joint meeting of the Sections on Pathology and Physiology, Internal Medicine, Experimental Medicine and Therapeutics, and Gastroenterology.

The Sections on Radiology, Proctology, Pediatrics, General Surgery, Internal Medicine, and Gastroenterology will join for a Symposium on Granulomatous Colitis and Ulcerative Colitis in Children.

Other symposia are being planned and scheduled.

The entire Scientific Program for the 1967 Annual

Convention will be published in the May 8 issue of the *Journal of the American Medical Association*.

Motion Pictures

Medical motion pictures and color television will be a feature of the Annual Convention of the American Medical Association again this year.

Medical motion pictures have become an integral part of the Annual Convention program. Movies are carefully screened and selected for quality, content, and diversity of subject matter. Some are chosen from the AMA library of medical motion pictures while others are picked from among films just completed. Several new films are usually shown for the first time at the Annual Convention. The total movie program is thus planned to achieve both variety and currency.

Medical motion pictures will be presented daily. At least five color television programs will be presented live, on a closed circuit from a Philadelphia hospital in cooperation with the University of Pennsylvania School of Medicine.

Several of the Scientific Sections will participate in this year's color television program.

Woman's Auxiliary

Mary Calderone, M.D., noted proponent of sex education, will be one of the speakers at the 44th Annual Convention of the Woman's Auxiliary to the AMA, June 18-22, in Atlantic City. Convention headquarters will be the Shelburne Hotel.

Dr. Calderone's talk, "Sex Education: Goals and Means," is scheduled for Tuesday morning, June 20, according to Mrs. Asher Yaguda, Newark, N. J., Auxiliary president.

Also speaking on Tuesday will be Charles L. Hudson, M.D., AMA president. Dr. Hudson's talk will be made at the luncheon honoring Auxiliary past presidents and AMA officers and trustees. The Auxiliary's contribution to AMA-ERF will be presented at that time, as well as awards to county and state AMA-ERF winners.

Mrs. Yaguda and Mrs. Karl F. Ritter, Lima, Ohio, president-elect, will be honored at a reception Sunday, June 18. Mrs. Ritter will be installed as president Wednesday, June 21.



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*Brest, A. N., et al.: J. New Drugs 5:329, 1965.

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The Midwest Society for Pediatric Research will meet October 31 and November 1, 1967, at the Southern Hotel, Columbus. Details may be obtained from William A. Newton, M.D., professor of surgery at Ohio State University College of Medicine, at Columbus Children's Hospital, 561 S. 17th Street, Columbus 43205.

The Chicago Committee on Trauma of the American College of Surgeons is sponsoring its Eleventh Post Graduate Course on Fractures and Other Trauma, April 19-22. It will be held in the John B. Murphy Auditorium at 50 East Erie Street, Chicago, Illinois.



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"George wants to know if it's okay to take his cold medicine now, Doctor, instead of seven o'clock?"

Wrestling and Weight Control Statement Issued by AMA

Wrestling is an excellent sport for high school boys, but its good name has been tainted by charges that ill-advised weight-control practices sometimes are being used, says a committee of the American Medical Association.

The AMA's Committee on the Medical Aspects of Sports has just issued a statement on wrestling and weight control. It is designed to answer questions that have been raised by coaches, physicians, and parents. The statement is in response to a request for guidance on the matter from the National Federation of State High School Athletic Associations.

Some young wrestlers attempt to lose an unsafe amount of weight to qualify for a lower weight division in competition. They mistakenly believe they will have a better chance of winning against smaller, lighter boys in this lower weight class.

This reasoning is not always sound, the AMA statement points out. Excessive weight loss hampers performance. This is especially apparent when the wrestler needs lasting power most—in prolonged exertion, such as tournaments.

The AMA committee suggested these steps to wrestling coaches:

1. Educate young athletes as to the importance

of a periodic medical examination and the advantages of a general, year-round conditioning program.

2. Assist the aspiring wrestler in an intensive conditioning program "for at least four weeks, preferably six, without emphasis on the scales."

3. At the end of this period and without altering daily training take his weight. Consider this weight his minimal effective weight—the weight level at which he will wrestle best.

4. Educate the boy and his parents as to defensible weight control measures that avoid fluctuation from this effective weight level.

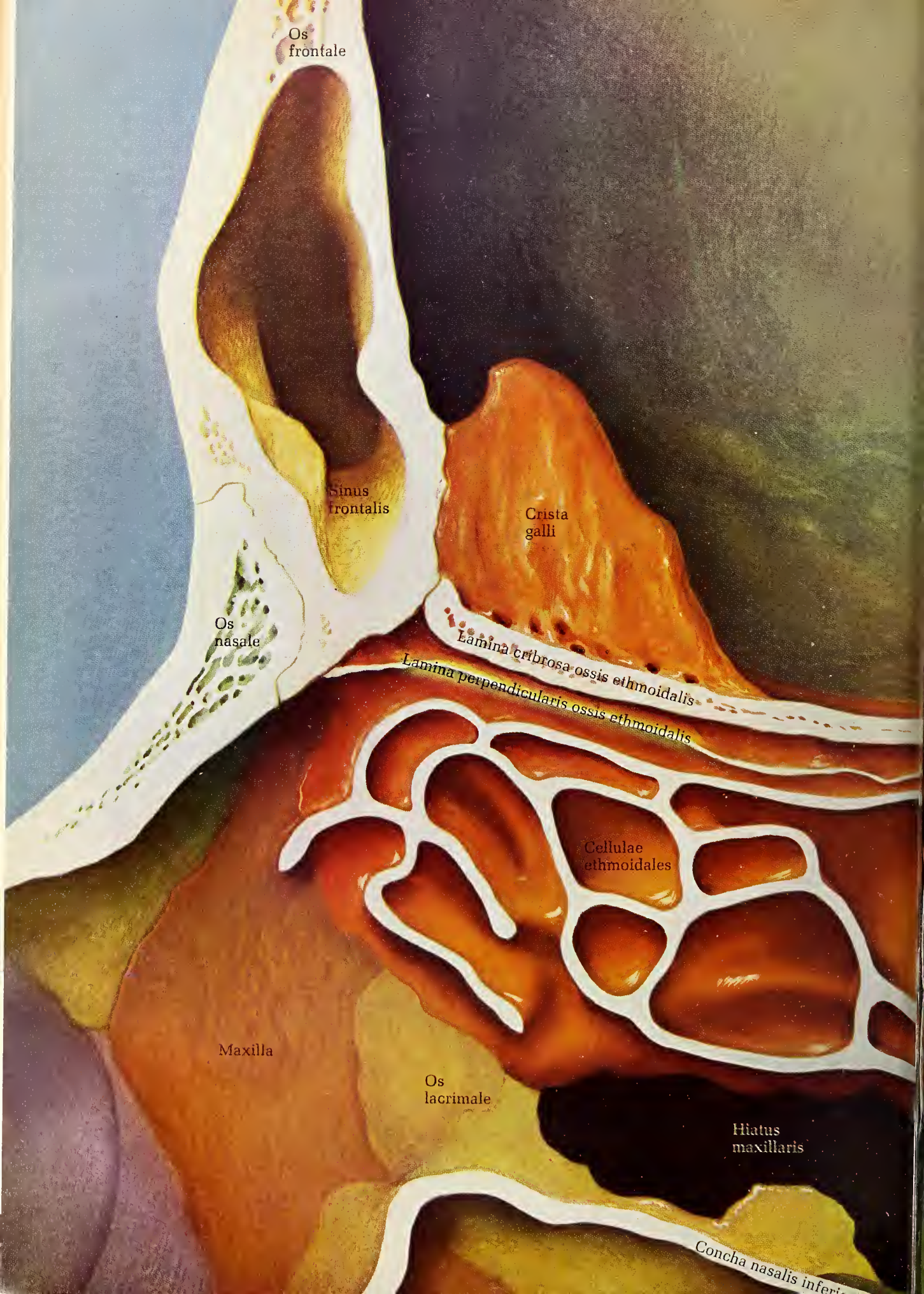
There is no reason why a given weight figure should be concentrated upon as a magic number, but arbitrariness in this regard seems to be one of the factors in negating a positive concept of weight control, the committee pointed out. "If a safe and equitable range of weight classes could be established in which an individual might compete during one season without further proof of weight," the statement said, "much of the temptation to tamper with weight control procedures would be removed."

Respect among coaches for defensible weight control concepts would make wrestling athlete-oriented instead of scales-oriented, the committee said. It is sufficient to attack indiscriminate weight control plans purely on their threat to peak competitive performances, the statement explained, for if this threat is appreciated, hazardous extremes won't be approached.

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Maxilla

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lacrimale

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Development of Special Diagnostic Methods

Relationship to Clinical Medicine

When most of our medical teachers were themselves students, the application of so-called basic sciences was limited to a few determinations of the end products of the organism's contrapuntal metabolic processes. Under these circumstances, the need for clinical expertise typified by Osler, Cope, and others became the hallmark of the mature physician or surgeon. Multiple eponyms arose for specific signs to aid the clinician in arriving at the all-important diagnosis. The character of the peripheral arterial pulse in aortic insufficiency, described by Corrigan; the ophthalmophelgia of thyrotoxicosis described by Moebius; the cutaneous embolism of a bacterial vegetation in infective endocarditis (Osler's node) all are examples of development of specific memory aids in physical diagnosis.

It must be remembered, however, that when these physical signs became important, the special diagnostic studies so common today were not available. The application of the study of the bicarbonate buffer system and its role in acid base balance of the blood as applied to patients by Singer and Hastings in 1929 has taken over three decades to reach widespread use in medical centers. Even in this case, the special demands of the postoperative open-heart surgery patient produced a demand for accuracy in biochemical assessment which fostered this growth. Use of blood gas analyses in the care of the seriously ill is not common today in community hospitals. The hydrogen ion concentration of the blood can no longer be considered a determination useful only in "research." The clinician's ability to recognize the presence of degrees of derangement of acid base balance is understandable and easily forgivable, as hydrogen ion concentration may be likened to the music of the Baroque period—at least two moving themes which are often in counterpoint—all the observer perceives is the end result.

Once acidosis from any cause is present, the function of the heart, kidney, brain, are all abnormal, and the decrease in myocardial performance leads to further decrease in cardiac output and a vicious cycle ensues.

Although Haldane and Bancroft called attention to the importance of the oxygen tension of the blood and the relation to environment partial pressure of oxygen, the importance of these observations and their use in the assessment of patients with respiratory disorders has been confined to medical centers where a special interest in pulmonary diseases exists. The decision of when tracheostomy is necessary in infants

(Continued on Page 430)

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Warning: If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Pyrazole compounds may potentiate the pharmacologic action of sulfonyleurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with great caution in the first trimester of pregnancy.

Precautions: Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should be closely supervised and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools or other evidence of intestinal hemorrhage. Make regular blood counts. Discontinue the drug and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The most common are nausea, edema and drug rash. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. Infrequently, agranulocytosis, or a generalized allergic reaction may occur and require withdrawal of medication. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

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Sperling, I.L.: 3 Years' Experience
with Oxyphenbutazone in the
Treatment of Rheumatic Disorders,
Applied Therapeutics 6:117, 1964.

Watts, T.W., Jr.: Treatment of Rheu-
matoid Disorders with Oxyphenbu-
tazone, Clin. Med. 73:65, 1966.

3 out of 4 osteoarthritics com-
pletely or markedly improved

76.9% of 407 patients

84.6% of 39 patients

(Editorial Continued)

with acute infectious upper airway obstruction "croup" is traditionally made by serial clinical assessment and is felt indicated when cyanosis appears and the child appears tired (metabolic acidosis is due to progressive hypoxia because of insufficient alveolar ventilation to meet the increased oxygen cost of increased respiratory effort).

In a hospital where "blood gas" analyses became available as a more or less routine determination only two years ago primarily to support a heart surgery program, it has been noteworthy to watch the ever-increasing use of these studies in a wide variety of clinical situations. Specifically in young patients with upper airway obstruction, it has been apparent that if *any* stridor is present, the $p\text{CO}_2$ will be abnormal; that if accessory muscles of respiration are mobilized (because of the stimulus of a high $p\text{CO}_2$), the work of breathing is increased. This "work" costs oxygen, and occurring as it does in the face of decreased ability to *take in* oxygen, leads to progressive hypoxia and metabolic acidosis. The *early* portions of these trends are *not* accompanied by dramatic changes in the clinical appearance of the patient. It is indeed fortunate that young mammals are relatively tolerant to hypoxia and this probably explains why so many infants will survive this adverse physiologic experience without biochemical assessment. A sounder method to decide when to relieve airway obstruction is the use of serial measurement of blood pH, $p\text{CO}_2$, and $p\text{O}_2$.

The successful use of cardiac catheterization, first practiced by Forstman in 1946, introduced a new dimension in the assessment of patients. Heart disease, rather than being observed in life, and confirmed at the autopsy table, could be suspected in the living patient on the basis of hemodynamic rather than clinical criteria. It is likely that many patients with rheumatic heart disease who, in the past, were thought to have pulmonary insufficiency (Graham-Steel murmur) probably actually had aortic insufficiency, and this might have been confirmed had left heart catheterization been available. Once cardiac catheterization became well established, it became apparent that elevation of the venous pressure and lowered peripheral arterial pressure, traditional hallmarks of cardiac failure, were *late* manifestations of heart failure in the classical Starling sense (increased unejected fraction) and were accompanied for varying periods of time by increased end-diastolic ventricular pressure, determined by cardiac catheterization.

To dismiss a cardiac murmur in childhood as "something he will outgrow" on the basis of clinical criteria is not necessarily defensible in the era of cardiac catheterization. This is even more true of children presented for cardiac surgery. Unlike exploratory laparotomy, exploratory cardiectomy in small patients with congenital heart disease is not prac-

tical because of the necessity of different surgical exposure.

At no time in the history of contemporary man has technology progressed so far. At no time have we been able to fly higher or faster, or dive deeper. All of these capacities are due principally to advances in technology. Yet applications of this vast body of knowledge to the life science have, by comparison, been relatively limited. Clinical signs represent signposts to point the way in the patient's journey to health. Today we need road maps for this perilous journey — more precise data. To paraphrase Laennec, treatment *is* useful, the diagnosis *is of importance*. —

JOHN H. KENNEDY, M. D., *Assistant Professor of Thoracic Surgery*, Western Reserve University School of Medicine, Cleveland, Ohio.

A Number of Ohio Physicians Named to Key AMA Posts

The American Medical Association recently announced that a number of Ohio physicians had been appointed or reappointed to important Councils and Committees. Following are the names of Ohioans reported to *The Journal* late in February, with the Councils and Committees on which each has been named.

Robert E. Reiheld, M. D., Orrville, has been appointed a member of the Council on Rural Health of the AMA.

Paul L. Weygandt, M. D., Akron, has been reappointed a member of the Committee on Medical Aspects of Automotive Safety.

Carl E. Wasmuth, M. D., Cleveland, has been reappointed a member of the Committee on Medical Aspects of Problems.

John R. Haserick, M. D., Cleveland, has been reappointed a member of the Committee on Cutaneous Health and Cosmetics.


Janet T. Dingle, M. D., Cleveland, has been reappointed a member of the Committee on Human Reproduction of the AMA.

Thomas E. Shaffer, M. D., Columbus, has been reappointed a member of the Committee on Medical Aspects of Sports.

Wendell A. Butcher, M. D., Columbus, has been reappointed a member of the Committee on Disaster Medical Care of the Council on National Security of the AMA.

Dwight M. Palmer, M. D., Columbus, has been reappointed a member of the Committee on Rating of Mental and Physical Impairment.

The number of veterans hospitalized for strokes and brain damage accompanying aging has more than doubled in eight years, according to the Veterans Administration.



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Side Effects: There have been occasional reports of insomnia and nervousness. Rare instances of mouth dryness, nausea, blurring of vision, dizziness, constipation, and stomach pain have been noted.



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Classifying Youngsters for Physical Education

Physical education is so important that great care should be used in excusing youngsters from a school's program in this area.

Schools should establish comprehensive programs that provide physical education for students with varying degrees of physical fitness. It's then the task of physicians, educators, and parents to cooperate in a program that classifies students according to physical ability.

These are some of the recommendations in a statement by the American Medical Association's Committee on Exercise and Physical Fitness that appeared recently in the *Journal of the AMA*.

"Each youth—healthy or handicapped—can be helped to discover activities in which he can take part with benefit to his health," the statement said.

Generally, students are placed in one of four categories for physical activity. These include:

1. Unrestricted activity—full participation in physical education and athletic activities.
2. Moderate restriction—participation in designated physical education and athletic activities.
3. Severe restriction—participation in only a limited number of events at a low level of activity.
4. Reconstructive or rehabilitative—participation in a prescribed program of corrective exercises or adapted sports.

Classifying students for physical education has frequently been discussed at the National Conference on Physicians and Schools, held biennially under auspices of the AMA. Physicians, educators, and public health personnel attending these meetings have generally concluded:

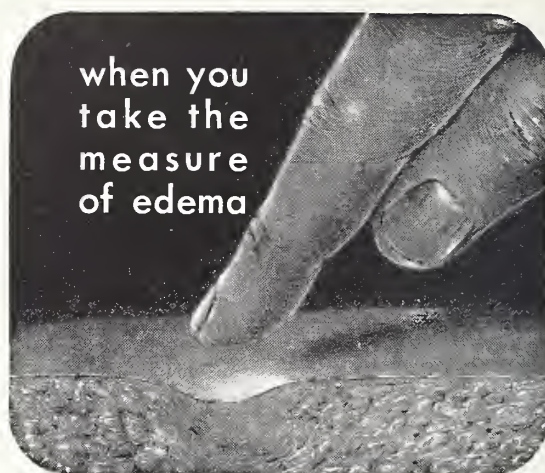
Better communication is needed among all parties in such a classification program.

The physician should provide all pertinent information on why an excuse from exercise has been issued. This can be done without divulging privileged information by providing an interpretation of the physical condition rather than medical findings.

Inadequate physical education programs must be strengthened. Many communities need to increase the variety of their activities.

Every student should have the kind of exposure to physical education which promotes understanding of the significance of physical activity in maintaining health and in motivating the individual to regular lifelong physical activity.

Dr. Lars Friberg, Chief of the Karolinska Institute of Hygiene in Stockholm, Sweden, and internationally known for his work in environmental health and applied physiology, has been appointed first visiting professor of environmental health at the University of Cincinnati. The visiting professorship is for six months.



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DOSAGE: Diuresis, initially 50 to 200 mg.; maintenance 25 to 150 mg., daily. Hypertension 50 to 100 mg. initially, adjusted to 50 mg. t.i.d. or downward to minimal effective dosage level.

WARNINGS: Use with caution in the presence of renal disease as azotemia may be precipitated or increased. In patients with advanced hepatic disease, electrolyte imbalance may result in hepatic coma. Dosage of coadministered antihypertensive agents should be reduced by at least 50%. In cases of suspected electrolyte imbalance, serum electrolyte determinations should be performed and imbalance, if any, corrected. Stenosis or ulcer of small intestine have been reported with coated potassium formulas, and surgery has been required and deaths have occurred. Based on surveys of both United States and foreign physicians, incidence of these lesions is low and a causal relationship in man has not been definitely established. Until further experience has been obtained, the use of the drug in pregnant patients should be weighed against possible hazards to the fetus.

CONTRAINDICATIONS: AQUATAG (benzthiazide) is contraindicated in progressive renal disease or dysfunction including increasing oliguria and azotemia. Continued administration of this drug is contraindicated in patients who show no response to its diuretic or antihypertensive properties. Severe hepatic disease is a relative contraindication. (See "Warnings" above.)

PRECAUTIONS AND SIDE EFFECTS: Electrolyte imbalance with hypokalemia (digitalis toxicity may be precipitated), hypochloremic alkalosis and hyponatremia may occur. Patients with cirrhosis should be observed for impending hepatic coma and hypokalemia. Other reactions may include blood dyscrasias, hyperuricemia and gout, nausea, jaundice, anorexia, vomiting, diarrhea, dizziness, paresthesia, photosensitivity and headache. Hepatic fever, tremor, confusion and drowsiness are signs of impending pre coma and coma in patients with cirrhosis. Insulin requirements may be altered in diabetes. AQUATAG (benzthiazide) should be used with caution post-operatively as hypokalemia is not uncommon. Potassium supplementation may be advisable pre- and post-operatively. There have been occasional reports of thrombocytopenia, leukopenia, agranulocytosis, aplastic anemia and precipitation of acute pancreatitis or jaundice.

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Comments on Current Economic, Social And Professional Matters

FLAWS IN PROPOSED COMPULSORY GENERIC PRESCRIBING OF DRUGS

"The myth of 'generic equivalence' was exploded long ago. There is as much difference between drugs with the same generic name as there is between people with the same family name. In the market place there are high quality products and low quality products and many grades in between. Medical, pharmaceutical, and other scientific annals, extending back more than 20 years, contain many convincing reports of investigations which persistently support the contention that generic identity does not necessarily assure equal therapeutic effectiveness."

Those are words spoken expressly for the medical profession. The quote is part of a talk given before the 1967 Conference on Legislation of the Texas Medical Association, by C. Joseph Stetler, president of the Pharmaceutical Manufacturers Association. Mr. Stetler speaks also from the experience of many years as head of the American Medical Association's Legal Department.

Proposed Federal legislation would compel physicians to prescribe drugs in generic terms for patients under Medicare or other federally financed health programs for welfare recipients.

Manufacturer identification has proven itself to be the most practical and reliable measure of trust in the prescribing of drugs, Stetler continued. If the medicine is the product of a quality manufacturer, he explained, the physician, nurse, and pharmacist can be certain that it has been carefully formulated and its production has been rigidly controlled throughout the entire process. Identification of a particular manufacturer also leads to a competition for recognition among quality producers, he added, and this is the patient's strongest safeguard.

"It is impractical with thousands of manufacturers to expect a government agency to guarantee that every product will be of high quality," the PMA official continued. "This would require analyzing every batch of every product made by every company, large or small—an obvious impossibility. Clearly, the public interest must be served by the manufacturer's sense of responsibility, his integrity and the strong motivation to excel which he feels

because of a prescribing system that places a premium on product and manufacturer identification."

Mr. Stetler points out that the argument is not against generic drugs *per se*. Objection is to limiting the physician's prerogative to prescribe the drug he thinks best for the patient.

MEDICAL PROFESSION NEEDS STRONG LEADERSHIP BY CONVINCED MAJORITY

"The (County Medical) Societies can, and must, proclaim the majority opinion of their members in a manner which leaves no doubt that the profession will not sacrifice its freedoms." That statement is an excerpt from an address given by Dr. Edward L. Doermann, in his presidential address to the Academy of Medicine of Toledo and Lucas County.

In our opinion, Dr. Doermann gave, not only the members of his society, but those of every county medical society, food for thought in his talk, additional excerpts of which follow:

"This past year, with the gross changes occurring in certain areas of our practice, has exposed our weaknesses and ineptitudes which might not otherwise be discernible. The past year has given us a taste, only a taste, mind you, of things to come, but not inevitably, in further Government control of and interference in our professional lives. This taste may yet prove to be a blessing in disguise, alerting us so that we may marshall our considerable forces to resist further erosions of our freedom.

"The ills I speak of are not peculiar to this Academy. I am sure they exist in some form throughout most of this country's medical societies on county, state, and national levels. There seems, for example, to be a disturbing lack of militancy in our profession, particularly and most ominously in areas of principle involving our place in this changing society. This is reflected in an apparent growing lack of fortitude to oppose what is patently bad, not only for medicine, but more importantly for the nation itself. This resignation to events is not universal, but can be seen all too frequently in individuals and in their medical societies as well.

"The legendary rugged individualism of the American physician has become in a sense a burden rather than an asset and is being used against us, seriously

compromising our effectiveness, so that the profession many times does not present a unified opposition to programs which we deplore but eventually accept. One of the tragedies of organized medicine, which an officer of a medical society has an opportunity to observe, is the tendency of the physician to dissipate his strength in national policy by disorganized effort, wasting what is actually a tremendous potential of effective power. Unanimity is not necessary or even desirable, but strong leadership by a convinced majority is.

"The membership desires leadership and direction from its national and local societies over matters concerning, for example, Medicare. Yet, when suggested courses of action are offered, which are legal and proper, but which may precipitate controversy, all too frequently much of the membership struggles briefly, then submits resignedly.

"How many have complained to their officers and to each other over having to certify and recertify, on a special form or on a special place, by separate signature that the Medicare patient whom you have sent to the hospital does indeed require hospitalization.

"How many are not aware from the material sent you by your societies that such a form is not required by law and yet how many have drawn the line at this example of bureaucratic stupidity and affront to intelligence and refused to be a passive party to this seduction of your rights? A small thing?

"Yes, but freedom is usually lost a bit at a time, relatively painlessly.

"One need only to talk to our colleagues who have come to this country from foreign lands in an attempt to escape this very thing that they now witness happening here to realize the primrose path down which we are allowing ourselves to be led. In some areas where physicians have shaken their apathy and become righteously indignant, resistance to this sort of intrusion has been most effective. In Ohio, our storm of protest over the ill-advised requirement that physicians (but no other group or profession) must sign a civil rights form when dealing with certain categories of people, successfully caused a rescinding of this insinuatingly insulting requirement. The importance of the effective results of strongly demonstrated resistance such as this must not be minimized. Carried to other problems, it can be just as effective. — — —"

"FDA Special Report: Drug Abuse — Bennies and Goofballs," is the title of a 20-minute black and white, sound film to discourage use of amphetamines and barbiturates without the advice of a physician. It is recommended for showing to the general public, particularly high school and college students. Free short-term loan from Public Health Service Audiovisual Facility, Atlanta, Georgia 30333, Attn: Distribution Unit.



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Los Angeles City Genl. Hospital...Los Angeles, California
Mass. Memorial Hospitals.....Boston, Massachusetts
Medical College of Virginia.....Richmond, Virginia
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Overlook Hospital.....Summit, New Jersey
Port Huron Hospital.....Port Huron, Michigan
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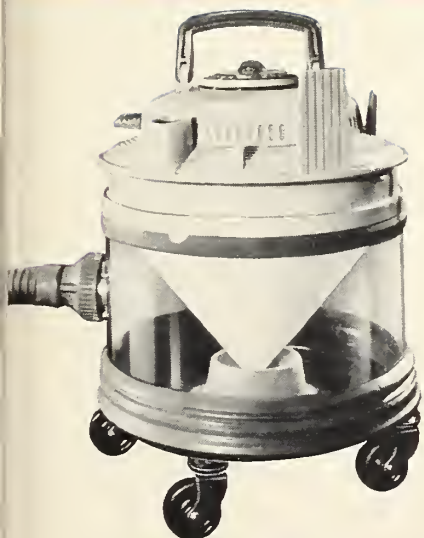
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Federal Biomedical Research Program...

AMA Urged by Special Commission to Endorse Federal Support of Research, but to Play the Watchdog Role

THE American Medical Association should support in general the Federal biomedical research program, but the AMA has an obligation to the public and to the medical profession to question any facet of the federal program which it may believe to be ill advised.

This is the primary recommendation of the AMA's Commission on Research, named by the Board of Trustees two-and-one-half years ago to assess the impact of Federal government support upon research itself, and upon medical schools, the education of physicians and the provision of medical services.

The Commission, headed by former U. S. Supreme Court Justice Charles E. Whittaker, of Kansas City, Mo., presented its report to the AMA Trustees recently.

Dr. Richard L. Meiling, Dean of the Ohio State University College of Medicine, a Past President of the Ohio State Medical Association, and a delegate to the AMA, was a member of the commission.

The Commission on Research was called into being by the Board of Trustees of the AMA to assess the impact of the Federal Government's support of medical research upon the conduct of research itself and upon medical schools, the education of physicians, and the provision of medical services.

Five Points of Inquiry

Specifically, the AMA Board presented the Commission with five charges. The first charge was to determine "the impact of Federal research grants on (a) medical education; (b) the institutions involved; and (c) the nation's scientific and technical resources."

The second charge was to determine "The effect of the expanding Federal research role on the broad areas of medical service outside of medical education."

The third charge was to determine "The effect of Federal spending on private giving and the ability of the latter to make a meaningful contribution."

The fourth charge was to determine "the scope of Federal medical research support and the mechanisms used."

The fifth charge was to make further conclusions . . . which the Commission should deem advisable.

Commission's Recommendations

At latest report, the full text of the Commission's report was being prepared for distribution. Following some 21 conclusions drawn in response to the foregoing charges, the Commission offered the following recommendations, given here in summary:

1. The American Medical Association should support in general the Federal biomedical research program. However, because in the public mind research tends to become enshrouded in such an aura of divinity as to exclude critical discussion and analysis of all that is advanced in its name, the AMA has an obligation to the public and to the medical profession to question any facet of the Federal biomedical research program which it may believe to be ill advised or which it believes to be in need of constructive counsel.

2. The programs of the National Institutes of Health (NIH) should be recognized for their contributions to the national biomedical research effort.

3. The Council on Medical Education of the AMA, in cooperation with other interested organizations, should be asked to make additional and progressive studies on the effects of research grants on teaching in medical schools. It should seek and recommend means for providing enhanced status and rewards for excellence in teaching.

4. The AMA should support responsible action designed to make available to selected schools of good potential which have not developed adequate research establishments special "development" funds to initiate or enlarge their research programs. These grants should also foster better geographical distribution of "centers of research excellence" among medical schools and universities.

Precise Identification

5. The AMA should urge that the purpose of grants be identified precisely so that the Congress and the nation may know, with reasonable certainty, what is being supported, as a basis for future decision making.

6. To strengthen the review mechanism, membership on NIH study sections should provide for a sufficient rotation to ensure continuous infusion of

(Continued on Page 451)

new blood and to prevent the development of a monolithic, elite, decision-making "establishment." The same principles of rotation should apply to the Advisory Councils of the NIH. While due attention should be given to such factors as geographic distribution, the main consideration in appointing members to the Advisory Councils should be professional attainment and eminence of judgment.

7. A new statutory mechanism of overall review and counsel, in an advisory relationship to the director of the National Institutes of Health, should be established in order to assist in overall program planning and to provide additional checks and balances on program decisions. Membership on this advisory group should consist of men and women of demonstrated professional eminence and judgment. (The Commission notes that the director of the NIH has, subsequent to the first drafting of this recommendation, created such an advisory body by administrative action. The Commission commends the director for this move.) We believe the advisory body should have independent status, under law, to assure that its recommendations and actions will have their intended impact regardless of changes in administrative leadership.

8. Accountability for disbursement of public funds should be maintained, but this accountability should depend primarily on strengthening of administrative capabilities of educational institutions.

9. The AMA should urge and support legislation providing for Federal reimbursement of all allocable institutional costs of research projects authorized and funded by the Federal Government.

More Local Choice

10. The AMA should urge and support legislative and administrative action designed to shift more decision-making responsibility for biomedical research from NIH to participating research institutions. To this end, increased use of the "institutional grant" and of the "program grant" should be actively supported. Developments relating to, or affecting, the mix of institutional, program, and project grants to academic institutions should be carefully and continuously studied and analyzed for future guidance.

11. The AMA, in cooperation with other interested organizations, should conduct workshops and seminars of academic and medical school leaders and of those Federal administrators who grant and administer Federal research funds, to review mutual responsibilities and relationships, to conduct discussions of developing problems, and to develop new techniques for the better use and management of the vast Federal funds now being made available.

12. Because of the rapid changes which are occurring in the organization of medical practice and the financing of health care, research in the delivery

of health care is of great importance and should be encouraged, provided it is conducted under proper auspices in accordance with sound research design and methodology.

Federal Grants Should "Supplement"

13. The imbalance between biomedical research and education, caused by the heavy, but desirable, Federal support of research, should be corrected by supporting measures that will materially increase both private and public funds for the support of the educational programs of the medical schools. First, among these measures, a more liberal income tax treatment should be allowed to the donors of private funds for medical education, to create increased incentives for them to contribute to medical education. Second, there should be allotted a greatly increased amount for operational expenses of medical schools, to be matched by those schools through private or local governmental sources. Every effort should be made to keep the Federal contribution on a supplemental basis, and the AMA should not support legislation that fails to do so.

14. The basic principles presented by the pharmaceutical industry on June 1, 1965, before the Subcommittee on Patents of the Senate Judiciary Committee, should be endorsed, namely:

(a) Provision should be made, in substantially every case, for the grant or license of exclusive rights in a scientific medical discovery to some industrial concern to assure that drug inventions, even if resulting in some part from government-financed research, are really developed and made commercially available to the people.

(b) When Government funds have solely or primarily developed the invention, it is equitable and rational for the Government to hold the proprietary rights to the invention and to receive reasonable royalties from a licensee, or from licensees, who will manufacture and commercially market the invention.

(c) Where Government funds did not solely or primarily produce discovery and development of the invention, the cooperating contractor-developer alone should have the proprietary rights in the invention.

15. The Board of Trustees should provide for a continuing watch and review of developments in the areas studied by its Commission on Research.

Dr. Thomas J. Croft, resident in neurosurgery at Metropolitan General Hospital, Cleveland, was decorated for outstanding service with an Army combat aviation unit in Vietnam. The Air Medal was presented by Colonel Rue D. Fish, Jr., head of the military science department at John Carroll University, Dr. Croft's alma mater.


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Some Statistics on Trends in Mortality from Cancer

Death from cancer is an increasing hazard to middle-aged men in most of the Western World and in Japan. In the United States in 1964, for example, somewhat over a third of all cancer deaths among men were registered at ages 45-64.

The largest increases at these ages, amounting to 16 per cent, were recorded in Italy and Portugal. France and nonwhite men in the United States showed the next highest increases, 13 and 12 per cent, respectively. Only in Norway and Sweden was there no change or a very slight decline in mortality from this cause. In the other countries and among the white men of the United States, the increases ranged from 4 to 8 per cent.

In great measure, these trends in cancer mortality among middle-aged men reflect the continued increase in the death rate from cancer of the lung and bronchus. No country escaped a sharp rise—not even Norway or Sweden. In Japan, the most affected, the death rate from lung cancer more than doubled over the decade. The smallest increases, somewhat over one fifth, were recorded for England and Wales, Portugal and Sweden.

The increases in other countries ranged from 33 per cent for Denmark to 74 per cent for Italy. In the United States the mortality from lung cancer rose 34 per cent among white men and 59 per cent among the nonwhite.

Another general feature of the trend in mortality from cancer has been the decline in the death rate from cancer of the stomach. Only Portugal, registering an increase of 12 per cent, provided an exception to this trend. The greatest decline in cancer of the stomach, 35 per cent, was recorded in Norway.

In the other countries declines ranged from 6 per cent in Japan to 32 per cent for white men in the United States. The nonwhite men in the United States registered a decrease of 22 per cent in the death rate from this cause.

Most countries reported an upward trend in mortality from malignancies of the esophagus and pancreas as well as from leukemia.

The reported mortality rate from all forms of cancer combined among men at ages 45-64 was highest during 1960-61 in the nonwhite male population of the United States, at 369.9 per 100,000. England and Wales were next with a rate of 362.6, followed by France with 336.2. The lowest rate was observed in Sweden, at 205.8 per 100,000, followed closely by Israel's rate of 209.4 and Norway's 212.7. For white males in the United States the rate in 1960-61 was 278.0.

For cancer of the lung, the highest death rate, 169.5 per 100,000, was registered in England and Wales. This was far above the corresponding rate in Germany, second highest at 96.9. The nonwhite male population of the United States followed with a rate of 96.3. The lowest death rate for cancer of the lung was recorded in Japan, at 22.5 per 100,000 males in the age range considered. Portugal was almost as low with 23.3, followed in turn by Sweden and Norway with rates about 36 per 100,000.

For cancer of the stomach, the death rate reported from Japan, 157.0 per 100,000, was more than twice the next highest, 73.3 in Portugal. The lowest mortality rate from cancer of this site was 19.3 for the white male population of the United States at ages 45-64; however, the corresponding rate for nonwhite men was nearly $2\frac{1}{2}$ times as high.—Metropolitan Life Insurance Co.

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Ohio Physician Serving on The Vietnamese Front

The accompanying photograph shows Captain J. Laurance Hill, resident of Columbus, Ohio, where he recently took residency training at Riverside Methodist Hospital, giving a preliminary medical checkup to a newborn Vietnamese baby, with the aid of Army Nurse 1st Lt. Jewell D. Staggs, of Columbia, Tenn.

The scene is the Bien Hoa Province Hospital, 20 miles north of Saigon. Both members of the team are with the 93rd Evacuation Hospital, operated by the First Logistical Command's medical arm, the 44th Medical Brigade at near-by Long Binh.

Doctors and nurses from the 93rd have been teaching modern medical methods to midwives at the Bien Hoa Hospital. The Army news release reported that Captain Hill has played an important part over the past several months in teaching methods of sterilization and helping with more difficult deliveries, including a caesarian section.

General Harold K. Johnson, the Army's Chief of Staff, recently observed that there are two battles going on in South Vietnam — besides the military battle, "there is the nation-building battle . . . where our officers and men are working side-by-side with the Vietnamese in the provinces, districts, and hamlets."

Toward this purpose, the U.S. Army's Medical Civic Action Program (MEDCAP) has two objectives: To give direct medical and health care to Vietnamese civilians, and to work with Vietnamese medical and health personnel.

Captain Hill noted that the idea behind MEDCAP is to "give the Vietnamese the ability to improve their own techniques. We learn from each other . . . the results have been most gratifying. I teach and advise them, but let them do the work."

In the first month of participation by the doctors and nurses of the 93rd Evacuation Hospital,



there were 303 deliveries with many of the more difficult ones being referred to Saigon hospitals. The Bien Hoa Province Hospital trains 22 midwife students every year, and most of the instruction is given by a Vietnamese midwife with three years of training.

Average daily costs per patient in Veterans Administration hospitals during the first quarter of fiscal year 1967 were \$34 in general hospitals and \$18.26 in psychiatric hospitals, according to the VA.



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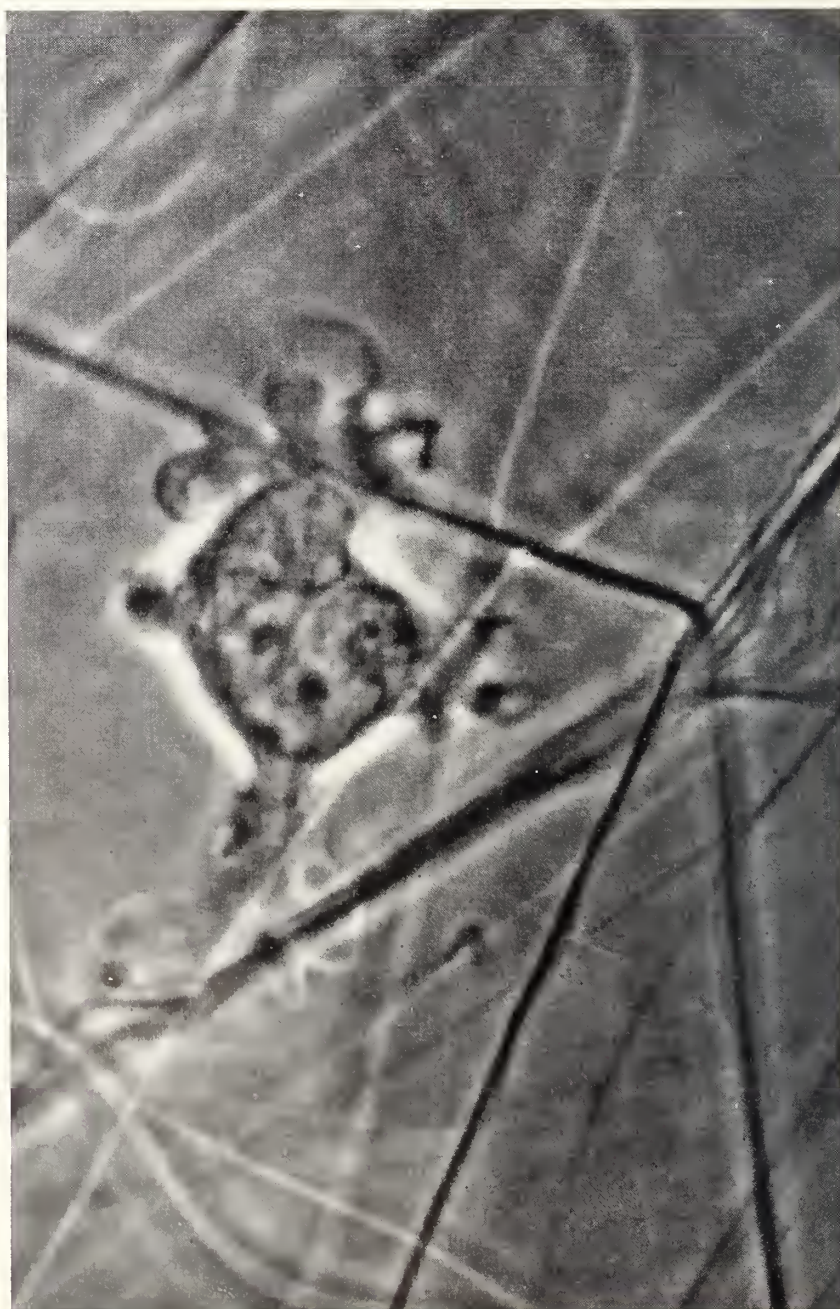
PHYSICIAN AND HOSPITAL EQUIPMENT

INFLAMMATION: A cellular fight for life

A SYNTEX REPORT based on recently developed hypotheses about topical corticosteroids, including the cellular theories of inflammation by Thomas F. Dougherty, Ph.D., University of Utah.

You are looking at a fibroblast fighting for life. This cell—one of the most common found in connective tissue—has literally been poisoned by cytotoxins released from other cells that have ruptured. Soon, if the abnormal activity of this fibroblast does not cease, it, too, will rupture and die—one more casualty in the inflammatory wave of destruction precipitated by injury.

Until a short time ago no one had ever witnessed such a scene at the cellular level. Now, through advanced cinemicrographic techniques, it is possible to view and photograph the inflammatory process as produced experimentally in living animal tissue. This method permits new insight into the mechanism of inflammation and the role of corticosteroids in therapeutic management. Equally important, these techniques shed new light on factors that may make one corticosteroid more effective than another—factors that can be correlated with other chemical, biologic, and clinical parameters.



Worldwide clinical experience confirms the predictable therapeutic potential of Synalar

It is particularly gratifying that the promise of the advanced chemical design and high order of bioassay activity of Synalar (fluocinolone acetonide) has been confirmed by widespread therapeutic application. Indeed, the impressive clinical response rate of Synalar has been documented in no fewer than 232 papers from 22 countries.

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For initiation of therapy: Cream 0.025%, 5 and 15 Gm. tubes, 425 Gm. jars; *for emollient effect:* Ointment 0.025%, 15 Gm. tubes; *for maintenance therapy:* Cream 0.01%, 15 and 45 Gm. tubes, 120 Gm. jars; *for intertriginous or hairy sites:* Solution 0.01%, 20 cc. and 60 cc. plastic squeeze bottles; *for infected inflammatory dermatoses:* Neo-Synalar® Cream (0.025% fluocinolone acetonide, neomycin sulfate, equivalent to 0.35% neomycin base), 5 and 15 Gm. tubes.

CONTRAINDICATIONS: Tuberculous, fungal, and most viral lesions of the skin, (including herpes simplex, vaccinia, and varicella). Not for ophthalmic use. **Contraindicated** in individuals with a history of hypersensitivity to any of the components. **PRECAUTIONS:** Synalar preparations are virtually nonsensitizing and nonirritating. However, the solution may produce burning or stinging when applied to denuded or fissured areas. In some patients with dry lesions, the solution may increase dryness, scaling or itching. While topical steroids have not been reported to have an adverse effect on pregnancy, the safety of their use on pregnant females has not absolutely been established. Therefore, they should not be used extensively on pregnant patients, in large amounts, or for pro-

Representative Clinical Results with Synalar*

Efficacy Documented in over 4,000 Patients

Condition	Number of Publications	Number of Patients	Significant Improvement†
Contact Dermatitis	27	750	713
Eczematous Dermatitis	21	472	409
Seborrheic Dermatitis	18	442	426
Atopic Dermatitis	24	460	426
Psoriasis	36	1,699	1,510
Neurodermatitis	18	351	324
Total	144	4,174	3,808

*Complete bibliography on request.

†Expressed by the authors as excellent, very good, good, complete remission of inflammation, etc.

longed periods of time. Prolonged use of any antibiotic may result in overgrowth of nonsusceptible organisms; if this occurs, appropriate therapy should be instituted. When severe local infection or systemic infection exists, the use of systemic antibiotics should be considered, based on susceptibility testing. **SIDE EFFECTS:** Side effects are not ordinarily encountered with topically applied corticosteroids. As with all drugs, however, a few patients may react unfavorably to Synalar under certain conditions. The neomycin in Neo-Synalar Cream rarely produces allergic reactions.

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Health Officers of Cincinnati, Ohio And the Problems of Their Day 1900 to 1960

KENNETH I. E. MACLEOD, M. D., M. P. H.*

PART X

(Continued from March Issue)

THE BIRTH RATE in Cincinnati and its environs rose in 1947 to the highest point ever recorded. Resident and nonresident births totalled 17,235 of which the residents totalled 11,570 with a rate of 25.3 per 1,000 live births. The resident infant mortality rate was 25.1 per 1,000 live births.

Accidents — A Leading Cause of Death

Dr. Wilzbach notes that accidents, as the fifth leading cause of death in Cincinnati in 1947, is associated with drinking.

The Health Department is assisting in the effort to prevent automobile accidents, which account for many accidental deaths each year. In Traffic Court, 133 drinking drivers submitted to the urine-alcohol test performed in the health department laboratory. From this number 99 per cent of the cases were tried and convicted . . .

The birth rate in Cincinnati and its environs rose in 1947 to the highest point ever recorded. Resident and nonresident births totalled 17,235 of which the residents totalled 11,570 with a rate of 25.3 per 1,000 live births. The resident infant mortality rate was 25.1 per 1,000 live births.

New Health Center

In 1948, demonstrating their "whole-hearted interest in health," Cincinnatians — at the last election — pass a \$200,000 bond issue for building a new health center and for improving the facilities of those now in operation . . .

And supported by funds from the State Department of Health, the Tuberculosis Registry reached a well-organized and useful stage in 1948. This registry records the names, addresses, work and home relationship, and stage of the disease making it possible for the health department to know, with few exceptions, the status and location of every case of tuberculosis in this city. [Except for those going unreported . . . K. I. E. M.]

The headings of the various sections of these reports indicate the scope of activities of the department: school hearing tests, diphtheria immunization, tuberculosis registry, cancer institute, health education, vital statistics, public health nursing, heart ex-

aminations, physical therapy, venereal diseases coordinator, enteritis study, smallpox emergency, industrial program, home visitation, child health, clinic visits, chest clinic, heart clinic, prenatal clinic, school health services, communicable diseases, tuberculosis deaths, laboratories, serologic examinations, narcotic and alcohol testing, accidents and drunken driving permit fees, inspection of tenements, collection and examination of swab samples (forks, spoons, glasses), water samples, swimming pools, rat control, farm dairy inspections, milk plant inspection, Grade A milk ordinance, producer applications, et cetera.

Cost of Operation

The total cost of operating the health department in 1948 was \$588,964.92. The total personnel in the employment of the department numbered 221 (see list on page 35 of this annual report).

In 1949 the health department was operating three health centers: Twelfth Street, Shoemaker (which was handed over to the city on January 1 of that year), and Madisonville which was acquired that year also.

Slum Clearance

Dr. Wilzbach notes that "The Board of Health is vitally interested in housing and slum elimination" — surely one of the first items of its concern since 1867. As far as tuberculosis was concerned, Dr. Wilzbach notes that "in spite of intensive control work, the number of tuberculosis deaths among non-whites in census tract number five has remained higher than in any other area." In an effort to find persons with tuberculosis, a chest x-ray program was carried out by the A. T. L. and the Health Department, assisted by the Public Health Federation and the Better Housing League. Early indications show that the survey was very productive.

In 1948 R. Eugene Wehr, M. D., M. P. H., was appointed as Registrar and Director of Medical Services.

It is noted also in this same report that a "city wide vaccination of dogs has driven rabies out of Cincinnati."

Annual Report — 1950

The Annual Report for 1950 is dedicated to William Muhlberg, M. D., who was the first person to receive the Public Health Federation's

*Dr. Macleod, Cincinnati, is Commissioner of Health, City of Cincinnati.

Submitted March 16, 1966.



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 Vitamin C (Ascorbic Acid) 300 mg
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award for outstanding service in public health. Possessing a keen interest in public health, Dr. Muhlberg has contributed a great amount of time, energy and money over the past 25 years to the advancement of the general health of Cincinnatians . . .

In the preamble to his report, Dr. Wilzbach notes that

The Mid-Century White House Conference on Children and Youth which convened in Washington, D. C., in December, 1950, was the fifth of a notable series of such conferences. The first was called by Theodore Roosevelt in 1909 at a time when the simple idea that the need of a homeless child is for a home, not an institution, was a novel one. The conference concerned itself with the factors that will help significantly in the development of an improved pattern of life for our children . . .

As far as health progress in Cincinnati, Dr. Wilzbach writes:

Reductions in the death rates from tuberculosis and syphilis are the lowest on record.

Completion of Cincinnati's first survey on the quality of housing . . .

A gift of a building to the city by Mr. W. K. Beckjord, President of the Cincinnati Gas and Electric Company, to be used as the new home of the Cincinnati Department of Health. [But never occupied as such because of other decisions made later.]

Civil Defense

The Health Commissioner installed as Chief of Health and Medical Service for the Cincinnati and Hamilton County Civil Defense Unit . . .

Assuming responsibility for more of the clinic and medical phases of the Babies Milk Fund, health clinics and those nursing activities recognized as a health department responsibility . . .

As the official agency for public health in Cincinnati, the health department spent \$736,167.34 in 1950 — or \$1.47 for every man, woman, and child to protect and promote the public health. Not included in the above total is an item of \$45,000 which is provided by the milk industry for city milk inspection . . .

He also quotes from Benjamin Disraeli, who said: "The health of the people is really the foundation upon which all their happiness and all their powers as a State depend . . ."

1951

In 1951 there were no cases of diphtheria, no deaths from diphtheria, no cases of smallpox (in the previous 51 years there had been only five deaths) a greatly lowered death rate from pneumonia (144.8 per 100,000 in 1900 as against 84.8 in 1951).

A comparison of the leading causes of death in 1900 and 1951 makes clear the striking changes in the pattern of death:

Leading Causes Of Deaths

1900	1951
Tuberculosis	Heart Disease
Pneumonia	Cancer
Heart Disease	Cerebral hemorrhage
Stillbirth	Accidents
Diarrhea-enteritis	Pneumonia
Nephritis	Arteriosclerosis
Cancer	Diabetes
Cerebral hemorrhage	Tuberculosis
Typhoid Fever	Nephritis
Diphtheria	Motor vehicle accidents

Lead Poisoning

Interest in lead poisoning was spurred by Dr. Kehoe and Kettering Laboratories and Children's Hospital. As a part of the effort, health department inspectors

collaborating with these physicians in an effort to evaluate some of the causative factors of cases of lead poisoning in children. This involved the careful inspection of homes in which lead poisoning had occurred . . .

Cincinnati births reached an alltime high in 1951 with a rate of 23.3 per 1,000 population, a total of 11,764 births being recorded.

The per capita expenditure on health in the department was \$154.

The staff — full and part time — numbered 261.

Annual Report — 1952 Highlights

In 1952 the following points of progress were noted:

1. For the first time in Cincinnati's history a full year passed without a single resident death from causes related to pregnancy and childbirth.

2. Resident tuberculosis deaths reached a new low with 130 deaths recorded.

3. Microfilming of birth and death records was started.

4. A new code governing the slaughter, dressing, inspection, and sale of poultry was adopted.

5. A division of occupational health was established.

6. Alcoholism was recognized as problem of the first rank.

7. A day care center regulation was adopted.

8. The summer roundup inspection of school children was reorganized.

9. The health department completed its first full year of providing courses in instruction in public health nursing to the collegiate schools of nursing at the University of Cincinnati and the College of Mount St. Joseph on the Ohio.

10. The Health Department collaborated with the Board of Education on drafting a manual of School Health Services and Procedures.

11. A mass blood testing program to bring to light unrecognized syphilis was conducted. Out of 1,683 cases uncovered more than two-thirds had not been reported to the Health Department.

12. Monies made available by councilmanic bonds provided the necessary funds for the construction of a new health center in 1953, in the Cumminsville-Northside area. City-owned land valued at \$25,000 was donated for this purpose.

13. A Division of Alcoholism was established as an Information and Consultation Center.

But problems troubled the department, for a polio epidemic occurred reaching a new high in 1952 of 129 cases.

The per capita expenditures by the Health Department rose to \$1.92 for the year.

(Concluded in May Issue)



Scientific Section

VOL. 63

APRIL, 1967

No. 4

Coarctation of the Aorta

Rationale for Early Surgical Correction

IVAN A. GRADISAR, B.S., DON M. HOSIER, M.D., and HOWARD D. SIRAK, M.D.

THE PURPOSE of this paper is to focus attention on the need for improvement in management of infants and young children with coarctation of the aorta and to dispel some of the misconceptions that prevail about the indications and the opportune time for operation in elective cases.

Ever since this operation was first introduced,^{1,2} there has been a reluctance on the part of physicians to refer patients under one year of age for surgery. In the infant group, it was thought safer to carry them along on digitalis and attempt to weather repeated bouts of heart failure and respiratory infections. The older children without symptoms were referred for operation only when they reached the age of 8 or 9 years. The rationale of the latter was to wait until the aorta had attained 80 per cent of its growth so that there would be an ample lumen at the anastomosis to carry them through adult life.

Our experience and that of others³⁻⁶ has now clearly shown that the mortality of infants with recurring symptoms is considerably higher when they are managed medically than if they undergo surgical correction when heart failure recurs. A technic that we have developed and used for the past several years assures a large anastomosis in small infants that is sufficient to last them through adult life.

Materials

The records of 178 patients with coarctation of the aorta who have been treated at the Columbus Chil-

The Authors

● Mr. Gradisar, Columbus, is a student at The Ohio State University College of Medicine—1967 (Med. IV).

● Dr. Hosier, Columbus, is Director, Division of Cardiology, The Children's Hospital; Professor of Pediatrics, The Ohio State University College of Medicine.

● Dr. Sirak, Columbus, is Head, Cardiovascular Service, and a member of the Attending Staff, Ohio State University Hospitals; Active Staff, The Children's Hospital; Professor of Surgery, The Ohio State University College of Medicine.

dren's Hospital during the past 15 years have been reviewed.

Operated Cases. Of the 178 patients seen during this 15 year period from 1949 through 1964, there were 107 males and 71 females. Ninety-two or a little over one-half, had surgical correction of their coarctation. The operative mortality was 11 per cent. The ages of the patients are shown in Table 1. It will be noted that the majority of the operations were done after the age of 2, and that the greatest mortality occurred in those under 2. Many of the patients had additional cardiac anomalies (Table 2). An associated patent ductus arteriosus or ventricular septal defect were present 35 per cent and 19 per cent of the time, respectively. There was a particularly high incidence of double lesions in the group under 2 years.

From the Cardiovascular Service, Division of Thoracic Surgery and the Division of Pediatric Cardiology, The Ohio State University and The Children's Hospitals, Columbus, Ohio 43210.

Submitted October 31, 1966.

Operations performed on infants under 2 years were invariably done to alleviate congestive heart failure that was refractory to medical treatment. The resulting poor-risk nature of these patients accounts for the high mortality rate of 47 per cent (Fig. 1). Six of the eight deaths resulted from cardiac arrest in the operating room. Nine of the patients under 2 who survived had a second cardiac lesion (Table 3).

By contrast, of the 75 patients who were operated upon after the age of 2 years, only two died. One of these patients died of hemorrhage following a second operation for correction of a mycotic aneurysm at the site of the initial repair. The other patient died of pneumonia and sepsis.

The Nonoperated Patients. Figure 1 compares the mortality figures by age of the operated with the non-operated patients. Of the 86 patients in the non-operated group, 75 were under 2 years. Thirty-nine of these died, causing a mortality of 52 per cent which is slightly higher than that for the operated cases in this age group. Figure 2 illustrates the longevity of of the 39 nonoperated patients who died under 2 years of age. Twenty died in the first week of life, 12 lived 30 days, but only seven survived longer than 2 months. Thus, 80 per cent of these nonoperated patients died within the first four weeks of life. It is interesting that of the 39 deaths, 20 had additional cardiac anomalies.

Operative Technique. If corrective operations for coarctation are to be performed on infants and young children, it is essential to use a method which will assure a large lumen at the anastomotic site. This is made possible in small patients by taking advantage of the fact that the aorta distal to the coarcted segment is always considerably (frequently twice)

TABLE 1. Age at Time of Repair

Age (Years)	Total	Died
< 2	17	8
2 — 3	21	0
4 — 8	34	0
9 — 15	20	2
	92	10

TABLE 2. Associated Cardiac Anomalies.
92 Operated Patients*

Patent Ductus Arteriosus	17
Ventricular Septal Defect	9
Mitral Stenosis	5
Pulmonic Stenosis	5
Large Poststenotic Aortic Aneurysm	4
Atrial Septal Defect	2
Aortic Stenosis	2
Mitral Insufficiency	2
Transportation of Great Vessels	1
Anomalous Pulmonary Venous Return	1

* Some patients had more than one anomaly

TABLE 3. Incidence of Associated Cardiac Anomalies in Patients Operated Before the Age of 2 Years.

SURVIVORS

Cardiac Anomaly in Addition to Coarctation	No. of Cases
Patent Ductus	4
Ventricular Septal Defect	2
Pulmonary Stenosis	1
Mitral Stenosis	2

larger in diameter than the aortic arch proximal to the lesion. Even in an infant, the lumen of this distal aortic segment is at least one-half the size of the normal adult aorta. To take advantage of this enlarged aorta, it is important to avoid using the stump of

MORTALITY IN OPERATED VS. NON-OPERATED PATIENTS

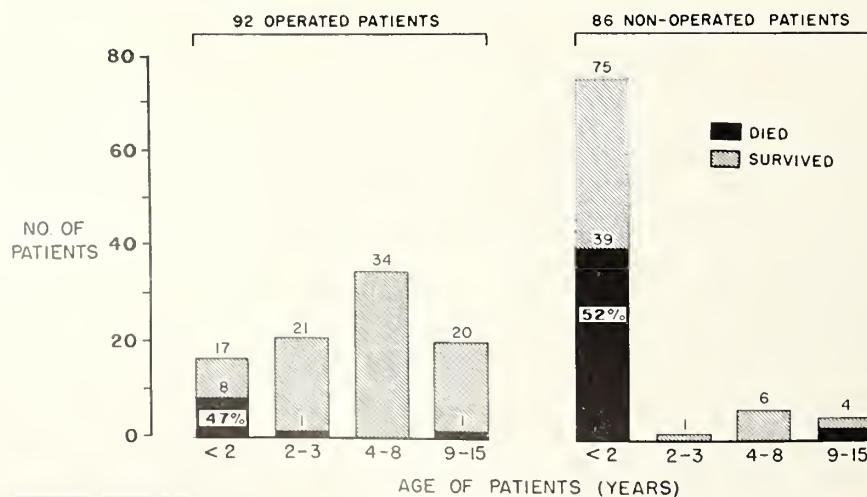


FIG. 1. Graph compares the operated and nonoperated patients. It emphasizes the comparatively few patients under 2 years that were referred for surgery in spite of the fact that medical management of the 75 medically treated patients produced a mortality of 52 per cent.

small-diameter aorta just distal to the left subclavian artery (Fig. 3) but instead to fashion a much larger lumen equal to that of the distal aorta. This is accomplished by using the lumens of the left subclavian artery and the aortic arch conjoined into a single large orifice.

The technique is illustrated in Fig. 4. With the proximal cross-clamp applied just distal to the left common carotid artery, the aorta is transected proximally so as to include the lateral wall of the left subclavian artery and medially, the aortic arch. Thus, the proximal transection is made higher than usual but leaving a broad connecting link of aortic tissue between the arch and the left subclavian artery. The distal transection is made at a point beyond any residual tapering in the aorta to remove all of the abnormal tissue. The posterior suture line is accomplished

LONGEVITY IN NON-OPERATED PATIENTS 39 CASES UNDER 18 MONTHS

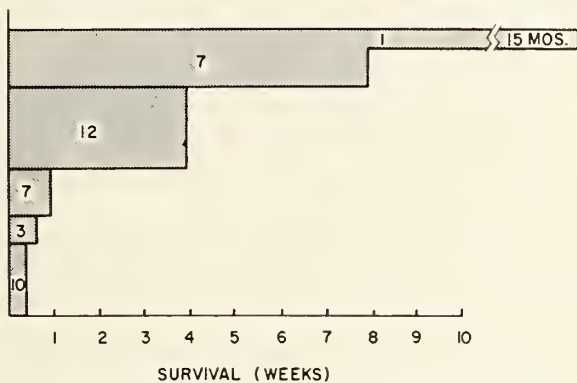


FIG. 2. This figure underscores the fact that the bulk of those 39 patients under 2 years who died (Fig. 1) while under medical treatment had a very brief survival period measured usually in weeks.

with a continuous 6-0 arterial silk while the anterior row is done with interrupted sutures of the same material.

Discussion

The average age at death of nonoperated coarctation patients is in the thirties which is less than one-half the life expectancy of the general population.⁹ The major causes of death being a consequence of the hypertension, such as cerebral hemorrhage, aortic dissection, and heart failure. Even though coarctation of the aorta produces little or no complaints during the early years of life, it does take a high toll in the adult years. In patients over 20, the hypertensive vascular changes may already be quite pronounced. These arterial changes are present in the vascular bed distal to the site of the coarctation as well as proximal to it. In such patients, the blood pressure will remain at borderline hypertensive levels at rest after repair of the coarctation. Thus, the surgical result is compromised and the patient's longevity is shortened.

In recent years, our operative mortality has been reduced in the infant-group with congestive heart fail-

INFANT - CHILD COARCTATIONS THE WRONG WAY

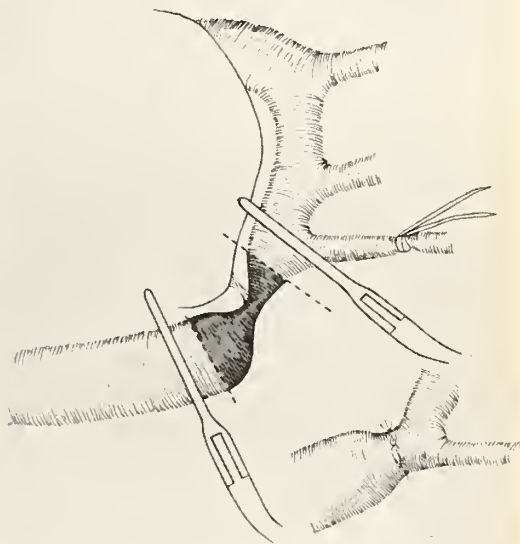


FIG. 3. The proximal aortic clamp is applied distal to the left subclavian artery which requires the transection to be made in a tapered portion of the aorta. This results in a constriction at the anastomosis.

INFANT - CHILD COARCTATIONS THE RIGHT WAY

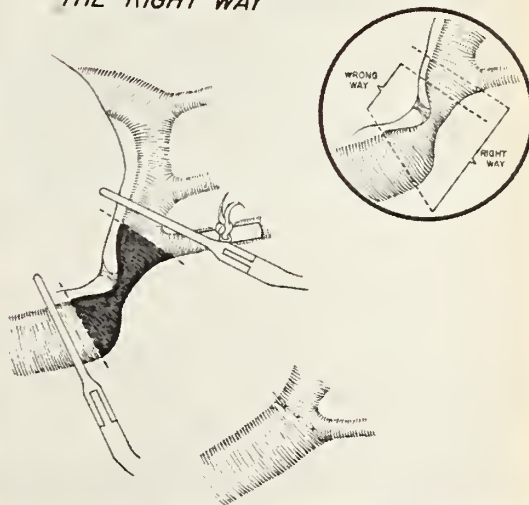


FIG. 4. The proximal aortic clamp is applied proximal to the left subclavian artery and the left subclavian artery is temporarily occluded with a tape tourniquet. The aorta is transected across the combined orifices of the left subclavian artery and the aorta. The added diameter of the left subclavian orifice compensates for the smaller proximal aortic diameter (in comparison with the distal aorta) to permit a large anastomosis.

ure. Others have reported a similar improvement in the surgical treatment of these difficult cases. Mustard⁴ has operated on 34 patients under 1 year of age with 20 survivors. Behrer¹² reported 17 infants, 1 to 19 months of age, with coarctation and associated patent ductus arteriosus all of whom were in congestive heart failure. There were nine survivors. Keith¹³ reported an operative survival in a moribund infant whose circulation was so poor that the incision did not bleed.

The information provided by our material definitely indicates that from a numerical aspect alone, the greatest improvement in the care of patients with coarctation of the aorta must be derived from the infant group, especially those in the first month or two of life. It is during this interval that mortality is greatest whenever symptoms of heart failure appear even with good medical management. The high incidence of associated cardiac anomalies, as noted in our experience, undoubtedly contributes to the difficulty in management of these patients.

From the technical aspect, the ease of exposure and the elasticity of the aorta make surgery easier than in later life. By using the operative technique described in this paper, or one similar in principle, an anastomotic lumen adequate to last throughout life can be obtained. When the abnormal area in the aorta is fully excised, growth at the anastomotic site will occur.⁷

From a physiologic point of view, there are many advantages to be gained from operating on the young infant. At birth he is well-hydrated and in an excellent nutritional state. He is in proper electrolyte balance and he has high levels of corticoids and inherited antibodies which better enable him to withstand stress and thwart infection.¹⁰ Therefore, it would seem logical that if the operative mortality is to be reduced in this infant group, surgery should be undertaken before all of the advantages afforded by this inherited munificence have been dissipated by the attritional effects of cardiac malfunction.

Summary and Conclusions

In 92 patients undergoing operation for coarctation of the aorta, there was an over-all mortality of 11 per cent with a 47 per cent mortality in the group under 2 years. All but two of the deaths occurred during the first two years of life. The majority of these were young infants. However, in 86 non-operated patients during this same period, there was


a 52 per cent mortality and 80 per cent of these occurred in the first four weeks after birth in spite of good medical management. Therefore, it is obvious that efforts to improve the over-all care of this lesion must be focused on this period of early infancy. The present high mortality in the operated and non-operated groups can be improved by a more aggressive surgical approach to those infants who develop heart failure during the first few weeks of life. At this early age, the infant is best able to withstand major surgery because his inherited robust physiologic state has not yet been depleted by the adverse effects of repeated and continuous congestive heart failure and its accompanying respiratory infection.

The authors are advocating that those infants who develop congestive heart failure after birth should be considered for surgery if medical management fails to produce a prompt and lasting remission of symptoms. If borderline heart failure persists or if failure recurs, then surgical correction should be undertaken promptly.

As for the older asymptomatic patients, the optimum time for elective surgery is around 3 or 4 years, before they start school. By using the operative technique described in this paper, an 'adult-sized' lumen at the anastomotic site can easily be produced.

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 OHIO'S No. 1 POSTGRADUATE PROGRAM OF THE YEAR: The 1967 Annual Meeting of the Ohio State Medical Association, Columbus, May 15-19. Make your plans now to attend.

Management of Acute Urinary Retention

LESTER PERSKY, M. D.

THE PATIENT with acute urinary retention is one who demands immediate attention in order to be afforded relief from overwhelming pain and discomfort. This anxious, suffering individual frequently has little time or interest in providing a detailed history or to permit a complete, labored physical examination. Many of these people, and the vast majority are men, need only to be observed briefly, and to have palpation of the lower abdomen in order for the attending physician to determine quickly what must be done. That is: decompression of the acutely overdistended bladder which is leading to the tenesmus, urgency, dribbling, incontinence, and often bleeding which is making the individual a most distressing sight.

Many times these patients complain just as bitterly about the urge to defecate as they do about the desire to void. If the patient is somewhat more tranquil, a more complete story can be obtained. Usually this is best reserved for when decompression has occurred. The examination of the prostate done in the face of retention is frequently also misleading. The overwhelmingly large prostate first felt before catheterization is, at times, surprisingly reduced after a brief period of constant drainage.

Catheter Technique

Once the decision has been made to proceed with catheterization, then analgesia can be afforded by immediate administration of a narcotic. At times, as in ureteral colic, instantaneous transient relief is afforded by the intravenous route of administration. This can be accomplished while collecting the material for the procedure and serves to allay anxiety without masking other findings. The selection of the appropriate solutions for washing the genitalia usually varies from institution to institution and needs no discussion. Commercially available sets now provide all the needed equipment for home use and avoid the need for improvisation and make-shift techniques. We have found it advantageous to use a sterile small lap sheet which affords protection from bed clothes while using the cleansing and prepping agents.

The choice of catheters is often based upon whether the patient will need prolonged drainage. If the immediate decision as to etiology favors benign pro-

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static hypertrophy, then a well-lubricated, balloon type retention catheter should be first used. We favor a No. 16 or No. 18 French with a small balloon as the initial catheter. The small balloon, however, may cause trouble since occasionally a 5 cc. bag gets pulled down into the urethra and will not drain. This usually occurs with very large median lobes, and, unfortunately can be ascertained only by trial and error. The experienced physician can prepare the genitalia and insert the catheter in a sterile nontraumatic fashion expeditiously and without resorting to forceful, painful techniques (Fig. 1). A maneuver



FIG. 1. *Technique for grasping catheter without contamination and without gloves.*

which will reduce discomfort and facilitate easy insertion of the catheter is the preliminary distension of the urethra with a topical anesthetic in a lubricant base. The overfilling of the urethra often affords a means of smoothing out mucosal folds and angulations, and the anesthetic gel reduces sensation at the same time. A sterile hemostat skillfully managed obviates gloves while avoiding contamination.

Complicated Situations

The difficulties which ensue from the uncomplicated passage of the urethral catheter are relatively minor when compared to those which may develop when undue force is employed or when unsuccessful

From the Department of Surgery, Urological Service, Western Reserve University and the University Hospitals of Cleveland, Ohio. Presented at the Annual Meeting of the Ohio State Medical Association, May 24-28, 1966, Cleveland.

attempts are carried on for too long and too vigorous a period of time. Most patients who have acute retention have clues as to diagnosis; i.e. a history of old stricture, a man in the prostatic age group, patients of both sexes in retention after anesthesia, and a variety of other readily discernible causes.

When obstruction is met, failure attends initial efforts, it is wise to consider the likelihood, therefore, of another cause other than simply inadequate force, spasm, or lack of cooperation. If it seems as though the resistance is at the level of the prostatic urethra, the use of a catheter with a curved tip, such as a coudé tip, may negotiate the bend and eliminate repeated assaults with filaforms and following sounds, or catheters of varying sizes. If however, the obstruction in the male is more distant, then one can attempt the use of these dilators to see if a previously unsuspected stricture is present. The use of stylets and splinting devices should be reserved for the urologist or surgeon who is familiar with these potentially dangerous tools and who uses them expertly. Before bleeding and trauma occur, no loss of face is incurred by seeking help from a colleague who daily deals with the intricacies of the male urethra.

When all efforts have failed in all hands, simple cystotomy by trochar or through a small suprapubic incision will quickly relieve the patient and afford time for recovery and diagnostic studies. We have seen, at times when the patient came from a long way, the use of polyethylene tubes such as are used for parenteral fluid administration. Such commercially available tubes are in every emergency ward and their use suprapubically without need for anything more than a needle stab relieves the patient completely. We have had one such catheter in place for several days while awaiting transport, hydration, and the ultimate insertion of a urethral catheter from below. Frequently, simple decompression relieves edema and in 24 to 48 hours, no difficulty is met while catheterizing.

We are constantly questioned about the need for slow drainage when decompressing an overdistended bladder. The rapid decompression, in my hands, has never led to any particular grief. However, I must in truth say that in the memory of several of the men in our senior staff, a rare patient would have a serious vascular collapse and rarely, death. This certainly gives one pause for thought, and I would not quarrel with anyone who insisted on a gradual decompression. The incidence of bleeding after relief of intravesical tension is unpredictable, but I have the feel-

ing that with a more gradual decompression this may be somewhat less.

Possible Infection


All urologists are constantly having to defend the catheter against the accusation that infection invariably follows its insertion and may lead to serious ultimate renal disease. However, although such infections do ensue, we like to feel that their incidence can be reduced by chemotherapy and ultimately by the surgical correction of the obstructive factors. Certainly significant upper tract sepsis is rare. In a large group of children with obstructions, we have demonstrated the ultimate sterility of the genitourinary tract despite the use of catheters and tubes during the acute phase of therapy.¹ Clarke has also shown reversal of infection in the vast majority of patients with prostatic disease, once surgery and convalescence have occurred.² In our paraplegics, with a double blind study, we have also significantly kept down upper tract disease with antibacterials,³ and similarly in obstetrics after catheterization at delivery chemoprophylaxis is helpful.⁴

Irrigating the catheter during the immediate post-insertion phase reduces the likelihood of obstruction from clots when bleeding takes place. We frequently employ a catheter which permits continuous flow in and out. When bleeding has ceased, the use of intermittent irrigation has certain advocates. Current opinion favors some type of continuous antiseptic irrigation as a means of avoiding urosepsis while awaiting surgery.⁵

The ever awareness of the need for gentleness in dealing with acute retention is of prime importance. Equally as important is the need to decide for how long drainage is indicated. Experience best dictates this. In the quickly reversible, postsurgical, post-anesthetic state the single catheterization is usually enough. Where true obstruction persists and requires ultimate definitive therapy, then we must resort to indwelling catheters while awaiting this curative procedure. Judgment, experience, and a delicate hand will lead to the successful management of these patients.

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 OHIO'S No. 1 POSTGRADUATE PROGRAM OF THE YEAR: The 1967 Annual Meeting of the Ohio State Medical Association, Columbus, May 15-19. Make your plans now to attend.

Long-Term Drug Therapy for Urinary Tract Infections

Comparison of Methenamine Mandelate, Nitrofurantoin and Sulfamethizole-Phenazopyridine, and Evaluation of The Triphenyltetrazolium Chloride Test

CHESTER C. WINTER, M. D.

THE INADEQUACY of intensive, short-term drug therapy for the treatment of acute urinary tract infections is of well-founded concern. Recurrent infections in women and girls are common, and the high incidence of chronic pyelonephritis has been attributed in part to silent bladder infections and vesico-ureteral reflux. The dire end-results of chronic pyelonephritis are familiar to most physicians. One current approach to this problem has been the application of continuous, long-term drug therapy. An evaluation of this mode of therapy was undertaken to determine its effectiveness, whether it is worth the expense and effort on the part of the patient, and to note any adverse effects of the drugs used. Three drugs used commonly on a long-term basis were chosen; they were representative of a chemotherapeutic agent (sulfamethizole), an antibiotic (nitrofurantoin), and a urinary antiseptic (methenamine mandelate).

Material and Methods

During a two-year period, 112 patients with recurrent or chronic urinary tract infections were treated, either therapeutically or prophylactically, on a long-term basis with antibacterial drugs. This study was not in the nature of an experiment but rather an intensive comparison of various forms of customary management. All drugs used were available commercially. There was no discrimination among patients as to sex, color, or age. No patients were included who had indwelling catheters, foreign bodies, or physical abnormalities believed to preclude cure of infection. Private patients were ultimately found to be more reliable and satisfactory for follow-up studies than the indigent.

The patients were categorized as to whether infected or not when initially seen, and were finally

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grouped as to cure, failure of cure, or development of infection while on therapy. All patients met the requirement for inclusion in the study of having had two or more episodes of urinary tract infections.

Initial examinations included culture and microscopy of voided and catheterized urine specimens, urinary pH, bladder residuum, excretory urography, cystoscopy, and, in the majority, cystography and radioisotope renography. Blood counts and serum creatinine determinations were made as indicated. As a matter of additional interest, a comparative study of urine microscopy, qualitative and quantitative culture, and the triphenyltetrazolium chloride test was carried out, and its results are included in this report.

The data on the comparative drug study are presented in Table 1 and the relative results of tests in Table 2.

Methenamine Mandelate Treatment And Results

Methenamine mandelate (Mandelamine®) was used in tablet (0.5 and 1 Gm.) and liquid (0.25 and 0.5 Gm. per 5 ml.) forms. It was prescribed in dosages recommended for weight and age. The average adult dose was 4 Gm. in four divided portions per day with correspondingly lower doses for children under 90 lb. Occasionally, very large adults received 1.5 Gm. doses. Because Mandelamine acts against bacteria by release of formaldehyde in an acid medium, the urinary pH was tested periodically

each day with nitrazine paper; when necessary to keep the pH below 5.5, ascorbic acid in divided doses ranging from 400 to 2000 mg. a day was prescribed.

Most patients tolerated the drugs without adverse reactions. Five patients developed nausea or emesis, of whom three were able to continue the drugs and the side-effects gradually diminished. Two subjects required withdrawal of the drug. The liquid carrier, especially of the more concentrated solution, was found too salty and unpalatable by some children. Both the 0.5 and 1 Gm. tablets were considered by some individuals difficult to swallow because of their size. When as many as eight tablets a day and frequent urinary pH tests were required, the therapy regimen was found burdensome. No patient dropped out of the study, however, because of these inconveniences.

Forty-three patients received Mandelamine from 4 to 80 weeks. Twenty infected patients were treated continuously and six became free of infection during follow-up periods of from 6 to 56 weeks. No improvement was seen in 11 patients during observations of 4 to 17 weeks. It should be pointed out that in the entire study some of the cured patients showed no improvement in the first few weeks of treatment. Some of the uncured patients were switched to another drug after three or four months of ineffective management (as in treatment with other drugs). Three infected patients had equivocal results during two, four, and five months' therapy.

Twenty-three patients with histories of recurrent urinary infections, but found initially to have sterile urine in this study, were treated prophylactically with the Mandelamine regimen; 17 remained uninfected through periods of observation lasting from 4 to 82 weeks. Most of these patients were females in the sexually active age period. They tolerated the drug(s) well and were generally pleased to be relieved of recurrent symptoms. However, in contrast to these favorable results were five patients initially uninfected who developed sepsis during 4 to 21 weeks of therapy, and one had an equivocal response.

Nitrofurantoin Therapy and Results

Nitrofurantoin was administered to 40 patients in dosage according to age (adults received 400 mg. in four divided doses per day and children correspondingly less in suspension or tablet form). It was con-

sidered prudent to reduce the dosage or frequency of medication later in prolonged treatment of some patients, especially if renal function was not completely normal. Six patients developed nausea or vomiting of a more severe degree than with either of the other drugs tested. One patient with reduced renal function developed severe electrolyte and fluid imbalance, as well as further reduction in kidney function that was reversed by withdrawal of the drug. No patient developed neuritis despite continuous therapy for as long as 17 months, demonstrating excellent tolerance of the drug. In a few patients, mild gastritis or nausea was obviated by food being taken with the medicine.

Fourteen of 32 infected patients became free of sepsis during periods ranging from 4 to 70 weeks of therapy. Two patients had equivocal results in 12 and 17 weeks, while 16 patients remained infected during periods of therapy from 4 to 66 weeks. Some of the patients undergoing long-term therapy were temporarily considered cured only eventually to suffer relapse. Eight patients uninfected at the onset tolerated prophylactic therapy without exacerbations from 4 to 64 weeks. No patient free of infection developed bacteriuria while on nitrofurantoin.

Sulfamethizole-Phenazopyridine Treatment and Results

Thiosulfil® Forte was administered to 35 patients. The adult dosage schedule was two 0.5 Gm. tablets, four times a day, while children received either tablets or the suspension in reduced doses. Eight infected patients attained sterile urine in treatment periods of from 16 to 78 weeks. Eleven infected patients remained so, while two had equivocal results in time of 4 to 56 weeks. Thirteen patients with sterile urine continued free of infection for 8 to 60 weeks. One patient treated prophylactically had an equivocal result while none of 13 developed an infection. One patient experienced nausea while, surprisingly, dermatitis, fever and headaches were not reported or noted. Blood dyscrasias were not detected in any patient under evaluation.

The Triphenyltetrazolium Chloride Test

Triphenyltetrazolium chloride (TTC test) is a chemical reagent that is purported to change the urine to a red color in a 4-hour incubation period at

TABLE 1. *Comparative Study of Drug Therapy in Chronic Urinary Infections*

Results in patients	Methenamine mandelate		Nitrofurantoin		Sulfamethizole	
	No. of patients	(%)	No. of patients	(%)	No. of patients	(%)
initially infected	20		32		21	
cured	6	(30)	14	(44)	8	(39)
not cured	11	(55)	16	(50)	11	(52)
equivocal	3	(15)	2	(6)	2	(9)
initially uninfected	23		8		14	
uninfected	17	(74)	8	(100)	13	(93)
infected	5	(21)	0	—	0	—
equivocal	1	(5)	0	—	1	(7)
Totals	43		40		35	

TABLE 2. Comparison of Tests for Infection of Urinary Tract

Tests for infection		in agreement with other tests				Correct No.	Accuracy (%)
		1 test	2 tests	3 tests	0 tests		
TTC	102	16	45	25	16	76	(75)
Colony count	93	23	16	47	7	81	(86)
Qualitative culture	59	22	12	20	5	48	(81)
Microscopy	102	24	24	43	11	88	(87)

37°C. in the presence of 100,000 bacteria per milliliter. In a number of patients in this study the TTC test was compared with bacterial colony counts, qualitative urine cultures in a separate laboratory, and microscopy of the centrifuged urine sediment. A colony count of 10^4 or more per ml. was considered positive evidence of infection and 10^3 as equivocal.

A microscopic examination showing bacteria, clumps of white blood cells, or more than six white cells per high power field was considered indicative of infection. Table 2 gives the comparative results. It can be noted that the quantitative urine culture and urine microscopy were judged to be of equal accuracy (86 and 87 per cent, respectively), while the qualitative culture method was of only slightly less value (81 per cent). The TTC test was lower in accuracy (75 per cent).

Comment

While the number of patients reported in this drug evaluation study is not large, adverse results in a significant proportion of each drug treated group was believed to obviate the need for the size series that would be required if the results had been uniformly successful.

Long-term, continuous antibacterial therapy was found to be of value in isolated instances, but in the majority it was no better than a schedule of intermittent therapy or the commencement of treatment of infections as they occurred according to the author's clinical experience. Possible causes of therapy failure were thought to be: (1) unreliability of patients taking prescribed doses of drugs, (2) aggravation of infection in the lower urinary tract in females by sexual activity, and (3) drug resistance on the part of bacteria. Furthermore, the physician must search for and eliminate factors that promote infections, such as congenital anomalies, acquired obstructive uropathy, foreign bodies such as stones or drainage tubes, and urinary stasis. These factors usually indicate appropriate modifications of the regimen of drug administration. Long-term, continuous therapy should have a reasonable chance for success if based on a careful evaluation of the patient. The high cost of continuous, long-term medication is of economic importance but should not be the primary factor in determining the type of management. Rather, the continued good health of the patient and the prevention of pyelonephritis and/or intractable lower urinary tract infection should be held as the chief objectives.

In this study, no attempt was made to use the knowledge of the kind of organism causing the infection in the choice of drug to be administered (although in most instances the bacteria were identified and antibiotic sensitivity tests were performed). Many patients failing to respond to one drug had the second or third drug prescribed.

The comparison of microscopy and qualitative and quantitative cultures with the 4 hour triphenyltetrazolium chloride test showed that there is no substitute for direct visual examination of the urine with confirmation of etiology by culture. Previous studies in our clinic¹ demonstrated that examination of stained sediment of specimens obtained by catheterization is 95 per cent accurate in the diagnosis of urinary sepsis. Microscopy was somewhat lower in accuracy as judged by the study here reported, which included examination of voided specimens. The TTC test was disappointing and failed to measure up to the value of microscopy and cultures. It is not recommended, therefore, as a screening test for urinary infections or as a substitute for microscopy or bacterial culture.

Summary

Three drugs given in a continuous, full-dosage regimen were compared as to their effectiveness in the management of chronic and recurrent urinary infections. Methenamine mandelate, nitrofurantoin and sulfamethizole-phenazopyridine were found to be of similar value and to be no better when administered in continuous fashion than when an infection is treated as it occurs or on an intermittent schedule. Patient intolerance to each drug was encountered in a few instances to the point of necessary cessation of therapy; only one serious toxicity was noted.

A comparison of urine microscopy, culture, and the triphenyltetrazolium chloride test (TTC or Uroscreen test) showed the last to be inferior as a method of diagnosing urinary tract infection.

Acknowledgments: The laboratory assistance of Dr. Robert A. Rehm, Miss Karen Fields and Miss Eleanor Williams is gratefully acknowledged. Supplies of Mandelamine (Warner-Chilcott Co.), Furadantin (Eaton Laboratories), Thiosulfil Forte (Ayerst Laboratories) and Uroscreen Test Kits (Knickerbocker Biologics, Pfizer Laboratories) were generously provided by the indicated companies.

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Idiopathic Hematoma of The Spermatic Cord

Case Report

ROBERT L. HELMLING, M.D., and ARTHUR T. EVANS, M.D.

SPONTANEOUS hematoma of the spermatic cord is a very rare entity. Differentiation of this lesion from direct and indirect inguinal hernia, and hydrocele, abscess, gumma and tumor of the funiculus may at times under certain conditions be difficult. Frequently the diagnosis is not made before surgical exploration. The following case of apparently spontaneous hematoma of the funiculus was a diagnostic problem which was resolved only at the time of surgical exploration.

Case Report

A sixty-two year old Negro man was admitted to the Cincinnati General Hospital with a two-month history of a "lump" in the right groin. The mass was asymptomatic until 15 days prior to admission when it began rapidly to

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FIG. 1. Artist's sketch showing hematoma of the cord.

increase in size. About five days prior to admission the patient noted mild pain over the mass, which radiated down his inner right thigh. Also, the right testicle was noted by the patient to be enlarged but not tender for about two weeks. He denied any history of trauma to the inguinal area or scrotum and had no urinary complaints or history of genitourinary infection. The remainder of the history was noncontributory.

From the Division of Urology of the University of Cincinnati Medical Center. Submitted February 8, 1967.

Physical examination revealed a firm, freely movable, non-tender mass measuring approximately 6 by 5 centimeters in the right groin adjacent to the external ring. No significant dilatation of the external inguinal ring was noted. The right testicle was slightly enlarged, but the epididymis felt normal. Transillumination of the right scrotal mass was possible. No inguinal adenopathy was apparent. The remainder of the physical examination revealed no abnormalities. Routine laboratory examinations were normal. X-ray of the chest and flat, upright, and decubitus views of the abdomen were interpreted to be within normal limits.

The diagnosis upon admission was incarcerated inguinal hernia or neoplasm of the spermatic cord.

At the time of surgical exploration of the mass, the patient was noted to have (1) a large cystic mass of the spermatic cord, (2) a small hydrocele of the right testicle, (3) a large right indirect inguinal hernia.

The mass associated with the right spermatic cord was noted to be cystic, egg shaped, measuring approximately 7 by 4½ centimeters. Upon sectioning the mass it contained "grumous, tan cheesy material with thin connective tissue septa forming compartments" (Fig. 1).

Microscopic examination showed the wall of the mass to be "fibrous and contained abundant hemosiderin" (Fig. 2).

Pathologic diagnosis was organized hematoma.

Postoperative course was uneventful.

Comments

Idiopathic or spontaneous hematoma of the spermatic cord appears to be a rare lesion. To date there are only three cases reported in the English literature.

One case reported as spontaneous hematoma of the funiculus occurred in an individual after he had been in a wrestling match. The preoperative diag-



FIG. 2. Microscopic section through mass of the cord showing organized hematoma with hemosiderin in the fibrous wall.

nosis was strangulated inguinal hernia.¹ The lesion was treated by excision.

The second case of spontaneous hematoma of the spermatic cord was thought to be a neoplasm preoperatively. Orchidectomy was performed before the diagnosis of hematoma was made microscopically.²

The third case was thought to be a neoplasm of the spermatic cord. An orchidectomy was performed. Postoperative diagnosis was hematoma of the spermatic cord.³

Summary

A case of idiopathic hematoma of the spermatic cord without history of trauma and occurring in as-

sociation with indirect inguinal hernia is presented. Preoperative diagnosis in this case, as well as two other cases reported in the literature, was neoplasm of the spermatic cord. The diagnosis was not ascertained until microscopic examination of the mass.

We believe that spontaneous hematoma of the funiculus may at times be actually associated with trauma unrecognized or denied by the patient.

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NLM EMBARKS ON ORAL HISTORY PROGRAM. — Through the medium of tape-recorded interviews by trained historians, the National Library of Medicine hopes to capture some of the significant knowledge and ideas of persons and events now locked in men's memories, which might otherwise be lost through the lack of adequate written records. The Library's program, it is hoped, will provide materials for those interested not only in the scientific advances of medicine, but also in the social forces that have shaped the conditions of practice and research.

Current plans call for interviews to be conducted by staff members of the History of Medicine Division, as well as by oral historians under contract to the Library. — *National Library of Medicine News*, Vol. XXI, No. 7, July 1966.

Chemotherapy in Disseminated Malignant Melanoma

CAPT. JAMES A. LEHMAN, JR., M.C., and JACK H. BERMAN, M.D.

AT THE present time the results of chemotherapy for malignant melanoma have been most disappointing. Many agents have been employed with little or no success and frequently the patients have been made worse by the therapy. The only impressive results with chemotherapy have occurred with phenylalanine mustard used for isolated regional perfusion.^{1,2} This modality is limited to use mainly in the extremities. Varying results have been obtained with such drugs as thiotepea and phenylalanine mustard intravenously.^{3,4} Oral agents, however, have given uniformly poor results.

The two patients presented in this report had disseminated disease when treatment with Velban® and chlorambucil was begun. Velban is a plant alkaloid which probably produced its antimetabolic effect by blocking cellular utilization of glutamic acid. Chlorambucil is an orally effective nitrogen mustard derivative and its action is similar to nitrogen mustard.

Case Reports

Case 1. A 62 year old white man had a subungual melanoma excised from his right index finger in March, 1963. He refused amputation and was not seen again until February, 1965. At that time he presented with a large right axillary mass, which had been enlarging for three months. Physical examination revealed a 10 by 15 cm. nodular bluish-black mass in the right axilla and chest wall (Fig. 1), and the liver was palpable 1 cm. below the costal margin. Chest x-ray revealed multiple nodular densities in both lung fields measuring up to several cm. in size. An attempt was made to remove the axillary mass because of pain, but this was not feasible. The patient was discharged only to be readmitted four months later because the mass had enlarged and several nodules had developed in his scalp. A chest x-ray (Fig. 2) showed a marked increase in the size, number, and extent of the pulmonary metastases. In an effort to achieve some palliation, it was decided to treat the patient with a combination of Velban and chlorambucil. He received Velban 10 mg. intravenously once a week along with chlorambucil 2 mg. orally five times a day. This therapy was continued from 6/24/65 until 8/12/65 when he was readmitted because of a convulsion. The remarkable findings were a marked decrease in the number and size of the metastatic nodules on the chest film (Fig. 3), and a decrease in the size of the right axillary mass. Subjective improvement had also been noted during this period. A presumptive diagnosis of cerebral metastases was made and the patient was discharged. Death occurred on September 11, 1965, and an autopsy revealed metastatic melanoma to the brain, lungs, heart and liver.

From The Divisions of Surgery and Internal Medicine, St. Luke's Hospital, Cleveland, Ohio. Submitted July 30, 1966.

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Case 2. A 41 year old white woman was admitted on October 13, 1964 because of a persistent brown vaginal discharge produced by a vaginal polyp. The polyp was excised and multiple cervical biopsies were taken. Microscopic sections revealed the polyp to be a malignant mel-



FIG. 1. Large nodular bluish-black mass in the right axilla and chest wall measuring 10 by 15 cm.

anoma with invasion of the cervix. Two weeks later a radical hysterectomy and total vaginectomy combined with a pelvic and bilateral inguinal lymphadenectomy was performed. There was no evidence of lymph node metastases microscopically, but there was superficial invasion of the vagina. The patient was discharged after an uneventful postoperative course.

In March, 1965, multiple pulmonary nodules were noted on a chest x-ray in the mid-lung zones (Fig. 4). In addition, a 6 cm. mass was palpated in the right pelvis. The patient was started on treatment with Velban intravenously (10 mg. a week) and chlorambucil (2 mg. four times a day). One month later a chest x-ray (Fig. 5) showed a marked regression of the pulmonary lesions with only one

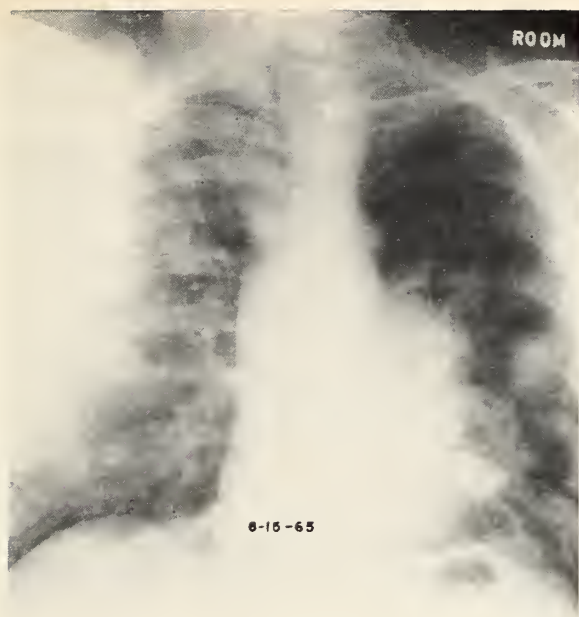


FIG. 2. Chest x-ray revealing multiple nodular densities in both lung fields measuring up to several centimeters in size.

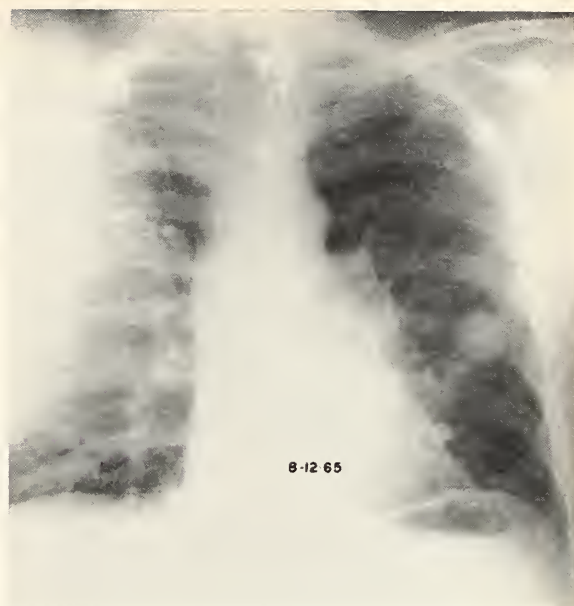


FIG. 3. Repeat chest film showing a marked decrease in the number and size of the metastatic nodules.



FIG. 4. Chest x-ray showing multiple pulmonary nodules in both mid-lung zones.



FIG. 5. Chest x-ray following therapy with only one nodule over the left anterior fourth rib remaining.

nodule over the left anterior fourth rib. The mass in the pelvis had also disappeared.

Four months later the mass in the pelvis had recurred. A chest x-ray, however, revealed only one nodule in the left lung field. She was continued on treatment but was readmitted in September, 1965, with multiple blue nodules in the skin. She died on September 29 of a massive gas-

trointestinal hemorrhage. Autopsy permission was not obtained.

Discussion

Both of these patients represent attempts at palliation of disseminated malignant melanoma. While the underlying course of the patients' disease may

not have been altered, there was definite objective evidence of regression of pulmonary and soft tissue metastases.

Ariel and Pack³ using phenylalanine mustard noted 70 per cent of the patients had transient subjective improvements varying from 1 to 10 months. Relief of pain was the most outstanding effect, but in no case did the authors feel the therapy prolonged life. Ariel⁵ reported on a five year cure of a primary malignant melanoma of the vagina treated by local radioactive isotope therapy. This patient, however, did not develop disseminated disease. Todd⁶ reported poor results with Natulan in the treatment of six patients with advanced malignant melanoma. Brindley et al.⁴ noted no response of malignant melanoma to nitrogen mustard and only a 12.5 per cent response to thiotepea.

It is apparent that with the compounds previously investigated the results in treating patients with disseminated malignant melanoma have been unsatisfactory. The present report presents two patients who obtained both a subjective and objective response to a combination of chlorambucil and Velban. The patients eventually became refractory to this therapy, and there is no evidence that this therapy prolonged life. Certainly more investigation of these compounds, for the treatment of disseminated malignant melanoma, is warranted by these encouraging results.

Summary

1. Two patients with disseminated malignant melanoma treated with a combination of chlorambucil and Velban are presented.

2. Good subjective and objective remission was obtained with these drugs and further investigation of this therapy seems warranted.

ADDENDUM

A 53 year old white woman developed a subungual melanoma of the left thumb in March, 1960. The patient was treated by partial amputation of the thumb, axillary lymph node dissection and regional perfusion. Recurrences in 1961 and 1964 were excised and the patient continued her occupation as a telephone operator. In March, 1966, she developed hepatosplenomegaly, ascites and weight loss. A chest film was negative. A diagnosis of disseminated malignant melanoma was made and the patient was started on treatment with chlorambucil and Velban. She had a remarkable subjective recovery and continued to do well until September, 1966, when she was readmitted in a terminal state. She died one week later and an autopsy showed metastatic melanoma in the liver, spleen peritoneum, lungs, and brain.

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THE DECEPTIVE ACID PHOSPHATASES.—Determination of the prostatic acid phosphatase is, theoretically, a specific test for carcinoma of the prostate, but the present laboratory techniques have produced too many false positives and false negatives to be dependable. There may be inhibitors or enzymes that interfere with these tests.

Until more exact enzymes are discovered, the present acid phosphatases should not be depended upon as a criterion for the type of surgical operation in carcinoma of the prostate, nor, without biopsy, should they be taken as an indication of prostatic malignant disease.—Jay R. Longley, M. D., Newport Beach, Calif.: *California Medicine*, 103:343-344, November 1965.

Hypothermia Associated With Hepatic Encephalopathy

Discussion With Case Report

NORTON J. GREENBERGER, M.D., RICHARD E. BRASHEAR, M.D., and LEOPOLD LISS, M.D.

IT HAS long been recognized that hypothermia may occur in association with several disorders including myxedema with coma,¹ uremia,² diabetic acidosis,³ hypopituitarism,⁴ and malabsorption.⁵ Recently, hypothermia has been described in patients with hypoglycemia.⁶ However, it is not generally appreciated that hypothermia may be associated with hepatic encephalopathy. We have been able to find only three reports in the literature concerned with this relationship.⁷⁻⁹

The following report is a detailed study of a patient with nutritional cirrhosis and hepatic encephalopathy, who developed marked hypothermia. The data to be presented suggest that the presence of hypothermia may be a valuable clue in predicting further deterioration in the mental status of patients with liver cell failure.

Case Report

A 38 year old housewife was admitted to the Ohio State University Hospital because of jaundice, anorexia, weakness, and increasing abdominal girth of two weeks' duration. Six months previously she had been hospitalized elsewhere because of jaundice and ascites and responded well to bed rest and diuretic therapy. There was a history of excessive ethanol ingestion for many years.

Physical examination on admission revealed an icteric woman who was mildly confused. The rectal temperature was 98°F, the pulse rate 88 beats per minute, and the respirations 20 per minute. The blood pressure was 100/70 mm Hg. A feto hepaticus and asterixis were present. The abdomen was protuberant due to obvious ascitic fluid. The liver was palpable 12 cm below the right costal margin and the spleen 8 cm below the left costal margin. There was minimal pretibial and pedal edema. The deep tendon reflexes were absent and position and vibratory sense impaired in the lower extremities.

Laboratory studies on admission revealed hematocrit 30 per cent, hemoglobin 10.4 Gm/100 ml, and white blood cell count (WBC) 12,800/cu. mm. The serum sodium was 133 mEq/liter, potassium 2.5 mEq/liter, chloride 91 mEq/liter, and carbon dioxide 22 mEq/liter. The total serum bilirubin was 26 mg/100 ml with a direct-reacting fraction of 16 mg/100 ml, serum glutamic-oxalacetic trans-

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aminase 330 units, serum albumin 2.1 Gm/100 ml and serum globulins 4.8 Gm/100 ml. Prothrombin time was 26 per cent of normal and alkaline phosphatase 12 King-Armstrong units. Fasting blood glucose levels during the first and second hospital days were 40 and 94 mg/100 ml respectively. Serum protein-bound iodine was 2.9 mcg/100 ml. The resin uptake of triiodothyronine-¹³¹I was 40 per cent (normal) on two occasions.

The patient's hospital course and pertinent laboratory data are shown in Figure 1. During the first week, the low serum potassium was corrected, and nutrition was maintained by intravenous fluid therapy and oral feedings. Examination of the cerebrospinal fluid, performed on the fourth hospital day, was normal. On the eleventh hospital day the patient's rectal temperature abruptly fell to 96.4°F. At this time she was confused and disoriented. On the thirteenth hospital day there was again a marked fall in the temperature from 98.6 to 94°F followed by the development of stupor. From the seventeenth through the twenty-second hospital day, the patient's temperature progressively increased toward normal. Coincident with this her mental status improved. Metabolic acidosis was corrected with sodium bicarbonate therapy. On the twenty-third hospital day, the temperature decreased to 93.5°F and shortly thereafter the patient again became stuporous. She subsequently lapsed into deep coma and died on the twenty-sixth hospital day.

At postmortem examination the liver was greatly enlarged, weighing 2400 Gm. Microscopic examination revealed changes of active Laennec's cirrhosis with marked fatty infiltration of the liver, extensive liver cell necrosis, and infiltration of inflammatory cells. There was focal intra-

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lobular fibrosis of the pancreas, but the islets appeared normal. The thyroid gland was normal. There were focal microabscesses in the kidneys, which otherwise were unremarkable. Examination of the brain revealed scattered microabscesses in the cerebral white matter, cerebellum, thalamus, hippocampus, and hypothalamus. The absence of reactive astrocytosis and little evidence of phagocytosis suggest that these changes were recent, and probably related to a terminal septicemia. There was pronounced astrocyte proliferation in the basal ganglia, especially marked in the caudate nucleus and putamen. In the mamillary bodies there was widespread necrosis, loss of neurons, and infiltration of lipid-laden macrophages. The periaqueductal area was also quite abnormal with intense glial proliferation. The changes present in the mamillary bodies and periaqueductal area were interpreted as being consistent with a diagnosis of Wernicke's encephalopathy, chronic and active.

Discussion

This patient had repeated episodes of confusion and disorientation, which were thought to be due to hepatic cell failure with encephalopathy. Although blood ammonia levels and electroencephalograms were not obtained, the presence of jaundice, markedly abnormal tests of liver function, asterixis, fetor hepaticus, fluctuating behavioral alterations, and the finding of active Laennec's cirrhosis at necropsy are all consistent with this diagnosis.

The patient had two separate episodes of marked hypothermia with rectal temperatures of 94°F and several temperatures in the range of 96°F. The question might be raised as to whether the hypo-

thermia was related to hypoglycemia. Although the patient did have a blood glucose value of 45 mg/100 ml during the terminal episode of hypothermia, a lower blood glucose level (40 mg/100 ml) was present on admission at which time the rectal temperature was 98°F (Fig. 1). Furthermore, several blood glucose values, obtained when rectal temperatures were less than 97°F, were normal. Thus, it would appear that there was no consistent relationship between blood glucose levels and hypothermia. In this connection it is of interest that in a report of five patients with hypothermia due to hypoglycemia, the blood glucose levels were less than 28 mg/100 ml in all cases.⁶ In that study the hypothermic episodes caused by hypoglycemia were rapidly reversed with the elevation of blood glucose to normal. However, in the present case intravenous infusion of hypertonic glucose on the twenty-fifth hospital day did not reverse the hypothermia.

The normal resin uptake of triiodothyronine-¹³¹I and the normal appearing thyroid gland at necropsy suggest that the hypothermia was not due to hypothyroidism. The normal arterial pH value obtained when the patient had a temperature of 94°F excludes metabolic acidosis as a cause of the terminal episode of hypothermia.

The mechanism of the hypothermia associated with

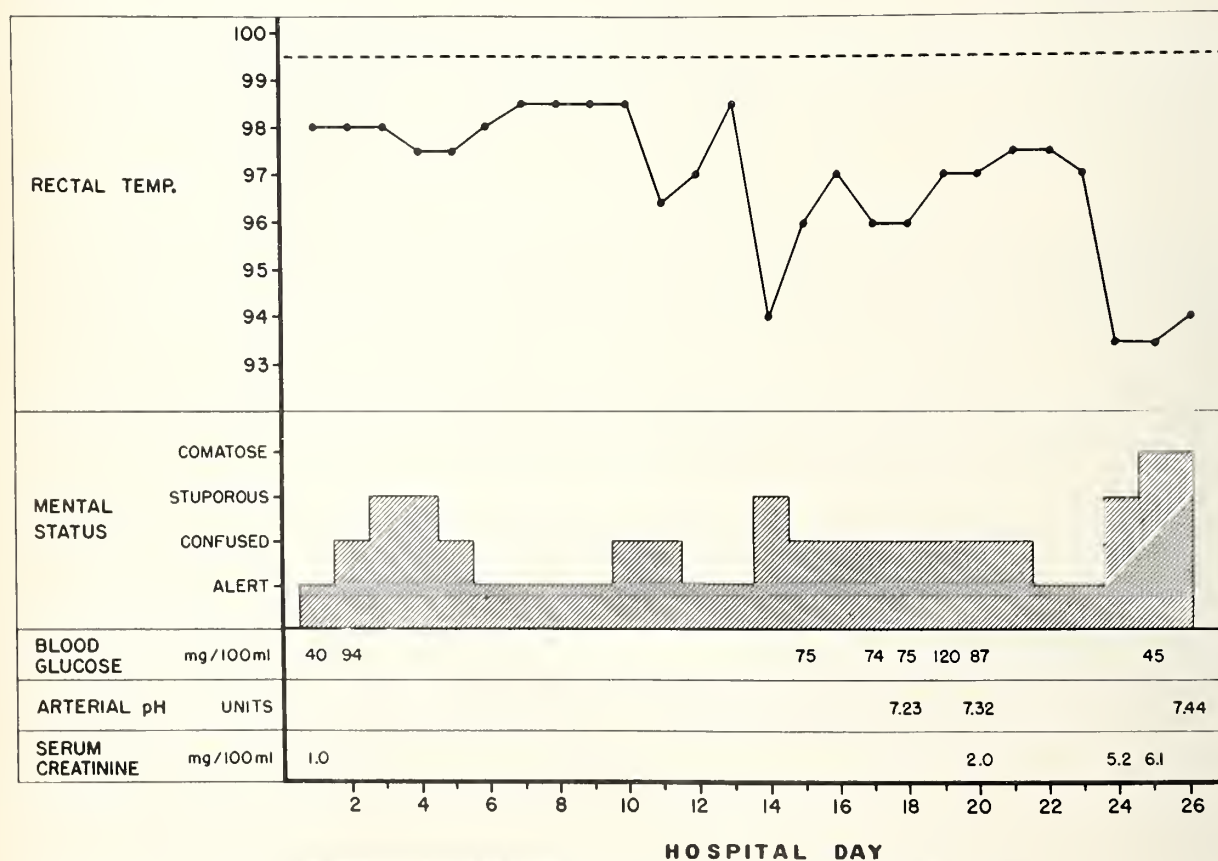


FIG. 1. Clinical Course and Laboratory Findings.

hepatic encephalopathy is not clearly understood. In several mammalian species, it has been shown that the metabolic activity of the liver contributes significantly to total heat production.¹⁰ In the presence of liver cell failure there is usually a marked impairment in intermediary metabolism, and this could conceivably result in decreased heat production and hypothermia. However, there is no direct evidence to support this postulate.

It has been suggested that, in patients with hepatic encephalopathy and hypothermia, there may be transient dysfunction of the temperature regulating center in the hypothalamus.⁸ Although lesions in the posterior hypothalamus in experimental animals have been shown to result in hypothermia,¹¹ no such sharply delineated lesions have been described in patients with hepatic encephalopathy and hypothermia.^{7,9} It should be emphasized, however, that it may not be possible to precisely localize the temperature center at autopsy. Thus, in the present case, it appears reasonable to conclude that the terminal episode of hypothermia was due at least in part to hypothalamic microabscesses with injury of the temperature center. Since these microabscesses were most likely related to a terminal septicemia, however, such a process cannot account for the repeated episodes of hypothermia observed during the eleventh through eighteenth hospital days.

There are three previous reports in the literature concerned with hypothermia and hepatic encephalopathy.⁷⁻⁹ Fisher and Faloon^{7,9} described an alcoholic patient with Laennec's cirrhosis and recurrent episodes of hepatic encephalopathy, whose temperature dropped to levels below 97°F on six occasions. It is of interest that on each occasion hypothermia was first observed on the day before the onset of stupor. In a recent clinicopathological conference, an alcoholic patient with hepatic encephalopathy was noted to have several episodes of hypothermia with temperatures as low as 94°F.⁸

It is noteworthy that in the case reported by Fisher and Faloon^{7,9} and in the present case, hypothermia preceded the development of hepatic encephalopathy on several occasions. Thus, the onset of hypothermia may be a valuable clue in predicting deterioration in the mental status of patients with liver cell failure. In addition, it is likely that hypothermia occurs more frequently in hepatic encephalopathy than is generally recognized.⁹

Summary

A patient with Laennec's cirrhosis who developed marked hypothermia in association with hepatic encephalopathy is described. The patient's rectal temperature decreased to values ranging between 94 and 96°F on three occasions. On each such occasion the onset of hypothermia either preceded or was associated with the development of stupor or coma. The presence of hypothermia may be a valuable clue in predicting further deterioration in the mental status of patients with liver cell failure.

Acknowledgment: We wish to thank Dr. J. Norman Allen for his critical review of the manuscript.

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ERRATUM: The author, Dr. John H. Kennedy, points out "an error in our article 'Cardiopulmonary Resuscitation' which appears on page 191 of the February 1967 issue of *The Journal* . . . As is often the case in condensation, something has been lost. In the statement in paragraph two on page 191: 'During a two year period, 41 per cent of 119 patients recovered completely following closed and/or open chest cardiac resuscitation.' *Should read:* During a two year period, 41 per cent of 119 patients *in whom resuscitation was begun within four minutes* recovered completely following closed and/or open chest cardiac resuscitation."

A Baedeker for Fat-Controlled Diets

III. The Diet Recommendation

HELEN B. BROWN, Ph. D.,* and MARILYN FARRAND, M.S.†

ANY diet prescription should include the characteristic features which are to be controlled. Just as milligrams of sodium are indicated for a sodium-restricted diet, or grams of protein, fat and carbohydrate for a diabetic diet, so should the amount of fat be stated for fat-controlled diets.

A low-fat diet may contain 15 to 30 grams of fat daily, the amount being specified in the prescription. Fifteen grams limits fat to that contained in two average servings of lean meat; a 25 gram fat diet includes an additional fat-containing food, such as ½ cup of ice cream or 2 teaspoons of margarine.

A vegetable-oil food pattern contains highly unsaturated vegetable oils in addition to 15 grams animal fat. This diet requires a prescription which includes not only the amount of fat but also its fatty acid content. We have tested quantitatively the hypocholesteremic effect of many such vegetable-oil diets and have determined the fatty acid composition necessary for serum cholesterol reduction.⁴ The following recommendations are based on the results of these tests.

A prescription for a vegetable-oil diet, in which only the type of fat is changed from that in the usual American diet, is: *Vegetable-Oil Diet: 35 per cent—40 per cent fat, 13 per cent S, 15 per cent P.* This indicates 35 to 40 per cent of the calories come

from fat—13 per cent *or less* from saturated fatty acids, 15 per cent *or more* from polyunsaturated fatty acids. A prescription for a vegetable-oil diet with a moderate reduction in the amount of fat should be indicated as follows: *Vegetable-Oil Diet: 25 per cent—30 per cent fat, 10 per cent S, 14 per cent P.* This means that fat provides 25 to 30 per cent of the

TABLE 1. Food Pattern

Food Group	Normal Diet	Fat-Controlled Diets	
		<i>Vegetable-Oil</i>	<i>Low-Fat</i>
MILK	2 or more*	2 or more skim*	2 or more skim*
MEAT	2 or more*	2, lean only*	2, lean only*
EGGS	4 or more weekly	up to 4 a week	up to 2 a week
FATS & OILS	All	Polyunsaturated	None

ADDITIONAL FOODS FOR ALL DIETS
Fruits and Vegetables; Low-Fat Breads and Cereals;
Sugars and Low-Fat Sweets

* Servings per day

calories—10 per cent *or less* from saturated fatty acids, 14 per cent *or more* from polyunsaturated fatty acids.

The amount of cholesterol in these fat-controlled diets is approximately 200 to 300 mg a day. When the physician desires less cholesterol, the amount should also be specified in his prescription.

Terminology commonly used for fat-controlled diets is often incorrect. Obviously the names "low cholesterol" or "low animal fat" are too vague to in-

The Heart Page is a periodic feature of *The Journal* containing brief, practical comments on subjects of immediate importance to practicing physicians. The comments are solicited by the Professional Education Committee of the Ohio State Heart Association.—Ed.

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TABLE 2. Approximate Composition of Diets in Per Cent of Calories

Diet	Protein	Carbo- hydrate	Fat	Saturated Fatty Acids	Polyun- saturated Fatty Acids	Cholesterol (mg/day)
<i>Low-Fat</i>	16	69	15	6	4	< 300
<i>Vegetable Oil</i>						
Moderate Fat Level	15	57	28	8	10	< 300
Customary Fat Level	14	48	38	11	17	< 300
<i>Average American</i>	12	45	43	18	5	750

TABLE 3. *Relative Fatty Acid and Cholesterol Composition of Various Kinds of Fat-Containing Food Products*

Kind of Fat	Saturates	Polyunsaturates	Cholesterol
ANIMAL PRODUCTS			
Meat, Poultry, Eggs, Milk	high	very low	high
Fish	low	high	high
Shellfish	none	none	high
VEGETABLE OILS			
Coconut and Cocoa Butter	high	very low	none
Nut, Olive	low	low*	none
Highly Unsaturated: Cottonseed, Corn, Soy, Safflower	low	high	none
HYDROGENATED OIL PRODUCTS			
Margarines, Shortenings	higher than original oil; amount unpredictable	lower than original oil; amount unpredictable	none

* Exception — walnuts are high in polyunsaturates and low in monoenes.

dicate the fat content desired. Occasionally the ratio of polyunsaturated to saturated fatty acids, the P/S ratio, is given. Since this value is only a proportion, the information necessary to construct a diet pattern, namely, the amount of fat and its composition, must also be stated.

Foods suitable for these diets are chosen from the food groups shown in Table 1. With proper food selection a varied, nutritious and palatable diet is readily attained. Approximate protein, fat, carbo-

hydrate, and fatty acids (as per cent of calories) and cholesterol in the fat-controlled diets are given in Table 2. Relative fatty acid and cholesterol content of various fat-containing foods is indicated in Table 3.

Selection of food products will be discussed in future Heart Pages.

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DIABETES AND CORONARY HEART DISEASE. — Studies of the incidence of coronary heart disease in patients with diabetes and of diabetes in patients with coronary heart disease have revealed an association between abnormal glucose tolerance and atherosclerotic vascular disease. Obesity is also closely associated with diabetes and is one of the "risk" factors in coronary heart disease. Weight reduction of obese patients and maintenance of desirable body weight is an important measure in the prophylaxis of both diabetes and coronary heart disease. Hyperglyceridemia is frequently found in patients with uncontrolled diabetes mellitus and is also associated with atherosclerosis. Resistance to exogenous insulin in hyperglyceridemic, obese and elderly persons suggests that there is some common etiologic factor in obesity, diabetes and atherosclerosis. — National Dairy Council, Chicago, Ill.: *Dairy Council Digest*, Vol. 37, No. 4, July-August, 1966.

A Clinicopathological Conference

From The Ohio State University Hospital, Columbus, Ohio

Edited Under the Auspices of the Ohio Society of Pathologists

J. B. McMILLAN, M. D., Ch. B., *President*

PRESENTATION OF CASE

FIRST ADMISSION: A 49-year-old white farmer was admitted to University Hospital because of chills, fever, and myalgia of five days' duration. A few days prior to admission he felt weak and tired. He consulted his family physician, who found that he was severely anemic and referred him to University Hospital. At the time of his admission the patient also related that he had had bleeding from his gums on a few occasions and had had one episode of epistaxis. He had had three or four episodes of sinusitis. He had been taking no medication.

On physical examination his skin and mucous membranes were pale. There was no lymphadenopathy. The lungs were clear. The liver was palpated two fingerbreadths below the costal margin. The spleen could not be palpated.

The hemoglobin level was 6.6 Gm./100 cc. The white blood cell count (WBC) was 40,000 per cu. mm. with 2 per cent neutrophils, 3 per cent small lymphocytes, and 95 per cent monoblasts. Bone marrow examination showed nearly complete replacement of the marrow by monoblasts. The platelet count was 200,000 per cu. mm. Other laboratory studies, with normal values, included alkaline phosphatase, serum glutamic oxalacetic transaminase (SGOT), van den Bergh, total protein, blood serology, and uric acid. The electrocardiogram was normal. X-ray examination of the chest showed a density within the left mid lungfield which was interpreted as probably secondary to old disease. The values obtained on pulmonary function studies, including maximum voluntary ventilation, vital capacity, and forced expiratory volume, were within normal limits.

The patient received 5 pints of blood by transfusion and was given therapy with Cytosan® (150 mg./day orally) and prednisone (20 mg./day in divided doses).

Second Admission

One month later the patient was readmitted. The hemoglobin level was 8 Gm., the hematocrit 27 per cent, and the WBC varied between 17,000 and 20,000 with the blood smear showing practically all

Presented by

- Bertha Bouroncle, M. D., Columbus, and
- F. E. Cuppage, M. D., Columbus;

Edited by Dr. Cuppage.

monocytes. He was given blood transfusions and was discharged after three days to continue on the same medication.

Third (final) Admission

One month later the patient had his third admission to University Hospital. Two weeks prior to admission he had a sore throat and was treated with various antibiotics, one of which was penicillin. He denied any cough. He had temperature elevation to 103° F., malaise and anorexia. He continued to take the prednisone, Cytosan, and the antibiotics. A few days prior to admission he developed swollen, painful nodes in the right groin.

On physical examination he was quite alert but appeared acutely ill and complained of pain in his throat and groin. His temperature was 103.4° F., the pulse rate 120 per min. and regular, respiratory rate 15/min., and blood pressure 120/80. The skin was warm and dry and contained no petechiae or purpura; however, there was generalized pallor. The tonsils were enlarged with whitish-gray exudate in both tonsillar areas. Bilateral tonsillar abscesses were suspected. The neck was supple and without masses. The lymph nodes of both inguinal areas were enlarged and tender. The lungs were clear. The heart rhythm was normal. A grade II/VI ejection-type systolic murmur was heard at the apex and along the left sternal border. The abdomen was nontender, and the liver and spleen were not palpated. The remainder of the examination revealed no abnormal findings.

The WBC at the time of admission was 20,400 with 2 per cent myelocytes C, 2 per cent small lymphocytes, 86 per cent monocytes, and 10 per cent monoblasts. The hemoglobin was 9.9 Gm. The platelet count was 74,000. Two weeks later the

WBC was 3,750 with 26 per cent neutrophils, 12 per cent myelocytes, 2 per cent small lymphocytes, 30 per cent monocytes, 20 per cent young monocytes, and 10 per cent monoblasts. The urine had a specific gravity of 1.012 and contained 40 mg. of protein per 100 cc. Cultures of urine and blood initially produced no growth; however, a throat culture contained a light growth of a gram-negative bacillus. Later, a light growth of coagulase-negative staphylococci, sensitive to all antibiotics except tetracycline, was isolated from the urine. The blood urea nitrogen level was 12 mg., uric acid 8.9 mg., and creatinine 1.2 mg./100 cc. Later in the patient's course the serum sodium was 118 mEq., CO₂ combining power 23 mEq., potassium 5.0 mEq., and chloride 91 mEq. per liter.

The initial chest x-ray examination revealed no change in the lesion in the left mid-lungfield, which was thought to be scar tissue. There was a small lesion in the right mid-lungfield that was not definitely identified on the previous film. A few days later a repeat examination showed a generalized hazy infiltration throughout both lungfields but most advanced in the superior segment on the right. This was thought to represent patchy bilateral bronchopneumonia. One day prior to the patient's death the x-ray showed a mass-like bilateral pulmonary infiltration which had increased since the previous examination.

Initially, the patient was administered oral penicillin, and the Cytosan and prednisone were continued. Because of monilial lesions in his mouth, he was also given nystatin. He continued to have a fever throughout the two weeks of his stay in the hospital. When rales developed in his chest, Chloromycetin® was begun, penicillin was given intravenously, and the nystatin was continued. Cytosan was discontinued a few days prior to his death, and he was given 3 mg. of nitrogen mustard on two successive days. Treatment was also begun on 6-mercaptopurine (50 mg. three times a day).

During the first week of his hospitalization the patient noted some improvement in his throat pain. While he was receiving a blood transfusion he began to have dyspnea that was not associated with chest pain, cough, or cyanosis. After the transfusion was completed his dyspnea slowly improved; however, he remained somewhat dyspneic throughout the rest of his hospitalization. He later became partially disoriented, which was thought to be due to hyponatremia. A lip lesion was treated with 800 roentgens in air to the lesion, and 800 roentgens in air were given to the anus because of drainage from hemorrhoids.

During the night of the 16th hospital day he was found to have no respirations or heart sounds, and resuscitative measures were unsuccessful.

An additional fact elicited historically was that a few years prior to his illness the patient lost approxi-

mately one quarter of his fowl flock because of an illness that was thought to be "fowl leukosis."

CLINICAL DISCUSSION

DR. BOURONCLE: This was a 49-year-old white farmer who was admitted to the hospital because of chills, fever, anemia, and bleeding. This was expressed in the physical findings by pallor, petechiae, purpura, and active bleeding. On physical examination the spleen, liver, and lymph nodes were not palpable. The differential diagnosis at this point includes acute leukemia, hypoplastic or aplastic bone marrow, and hypersplenic disease involving red cells, platelets, white cells, or all three elements at the same time. Although the peripheral blood smear is often helpful, frequently one must resort to a bone marrow examination for aid in the diagnosis. The bone marrow in a hypersplenic syndrome would contain normal cells but would show hyperplasia of these elements. If this were thrombocytopenic purpura, there would be an increase in normal megakaryocytes. If it were hemolytic anemia, there would be normoblastic hyperplasia, sometimes with some maturation of erythrocytes. If this were splenic neutropenia, one would find a leukocytic hyperplasia with immature cells in some of the cases. In aplastic anemia one usually obtains a marrow very easily with fragments, but when one examines these fragments microscopically they are predominantly replaced by fat and the central marrow is either gone or markedly decreased. In contrast, in a leukemic process one finds abnormal leukemic cells in the bone marrow.

Acute Monoblastic Leukemia

In this patient the diagnosis is apparent. The peripheral blood of this patient initially contained 40,000 white cells with 2 per cent polys, 3 per cent small lymphocytes, and 95 per cent monoblasts. The diagnosis of acute monoblastic leukemia was established, and this was confirmed by the fact that the bone marrow was practically replaced completely by monoblasts.

Certain factors distinguish the types of acute leukemia. Acute lymphoblastic leukemia is probably the only leukemia that frequently will have a palpable spleen and lymph nodes. Acute monoblastic leukemia and acute myeloblastic leukemia usually do not have a palpable spleen. In this patient the spleen was not palpable, which is consistent with acute monoblastic or myeloblastic leukemia. Another frequent finding in cases of acute monoblastic leukemia is hyperplastic gums. It doesn't occur in all patients with acute monoblastic leukemia and it is not pathognomonic of acute monoblastic leukemia. We are accustomed to having dentists refer us patients with acute monoblastic leukemia.

Other things that are very characteristic of acute monocytic leukemia are infiltrative lesions and rectal lesions. Many of the patients will develop rectal fissures and abscesses which come after the lesions

are infiltrative. In the early stages of these infiltrative lesions they will respond locally to x-ray therapy. Once the lesions have become infected, it is very hard to treat them locally. Skin infiltrations are also very common.

Although acute monocytic leukemia usually has a rapid onset and course, this is not always the case. A few years ago I reviewed the charts of about 400 of our patients at University Hospital with acute monoblastic leukemia and found that 8 to 10 per cent started out with chronic leukemia. Most of these patients were diagnosed by the hematologist who had seen the patient with a hypoplastic bone marrow. Before we go any further, may I see the slides of the peripheral blood?

Cytology

DR. CUPPAGE: Photographs of the antemortem peripheral blood show representative cells, upon which perhaps you would comment.

DR. BOURONCLE: Many of the cells are consistent with monoblasts. They are large with prominent nucleoli. No specific granules indicative of myelocytic cells are present. This smear is most consistent with acute monoblastic leukemia.

Treatment

Thus we have established the diagnosis of acute monoblastic leukemia. We should say a few words about the treatment of this disease. Two forms of treatment are available for acute monoblastic leukemia at present. The conventional therapy of acute monoblastic leukemia is Purinethol®, or 6-mercaptopurine. The accepted dose is 2.5 to 5 mg./kg. This has been the treatment of choice for many years. We did a study, I think two or three years ago, with this type of treatment. Approximately 21 to 23 per cent of our patients with acute monoblastic leukemia treated in this manner went into some form of remission, either partial or complete. Some of them were supported with steroids while others were not, and so it doesn't seem that the steroid support influenced the remission.

The second choice for conventional therapy of acute monoblastic leukemia has been Cytosan. I don't think there are any statistics in our group or in any other group with Cytosan alone, but in my personal experience I would say that not more than 3 to 4 per cent of the patients who already have relapsed on Purinethol ever had a remission, partial or complete, on Cytosan. It is not really the treatment of choice. In acute myeloblastic and acute monoblastic leukemia at present, the best one can hope for, for partial or complete remission, will be 21 per cent of the cases. This means that of ten patients you see eight are going to die. This is pretty discouraging. So we are searching for new ways to treat these patients. This brings us to the concept of combination therapy using massive doses of agents.

University Hospital is now involved in a controlled study of the use of combination therapy. Group 1 patients are placed upon high doses of methotrexate. Group 2 goes on high doses and short courses of Purinethol, and group 3 goes on a combination called VMPP, consisting of vincristine, methotrexate, prednisone, and Purinethol. We give them this combination in short courses repeated every 10 to 14 days. The results of this combination therapy are not yet available. A fourth group of patients receives the same combination as group 3 but in larger doses. To my knowledge there are no reports yet from this group of only a few patients.

Complications

With the diagnosis in hand, we should again turn to our patient for a discussion of the complications of this disease. At the time of readmission the patient had a fever of 104°F., with a cough and sore throat, and was acutely ill. Obviously this patient at this time had an infection. Infection is a common, life-threatening complication in leukemic patients and is often related to the antimetabolic therapy for the neoplastic cells. What treatment do we have to help us with these infections? Urine culture and a blood culture were negative. This patient had already been treated with penicillin before he came into the hospital. A light growth of a gram-negative rod was cultured from the throat. In a case like this a light growth may be significant. Here we are faced with a patient with an infection which we know is localized to the lungs. I would like to ask Dr. Harris to show us the x-rays.

Radiologic Findings

DR. HARRIS: Chest films taken at the time of his last admission illustrate the rapid course of the pulmonary infiltration over a period of less than three weeks. The initial admission film shows a barely visible infiltration in the left midlung and perhaps an additional one in the right apex. Six days later he had fairly large, patchy infiltrations scattered throughout both lungs, and four days later there were large, well-defined, rounded areas of infiltration in both upper lobes and possibly also in the lingula of the left upper lobe. There was no pleural fluid to speak of. I believe that the diagnosis radiologically would be some type of infectious process — either bacteria or fungus. From the rapid onset and the rounded snowball-like lesion we might wonder about staphylococcal, pneumococcal, or possibly monilial or cryptococcal infection. I cannot exclude the possibility that these are actually leukemic infiltrations. No other radiologic examinations were performed.

DR. BROWNING: Can pulmonary moniliasis complicating this type of therapy appear as such a circumscribed lesion?

DR. HARRIS: Yes, I have seen some that have given multiple small, rounded infiltrations.

Infections

DR. BOURONCLE: The National Cancer Institute reported a series of infections in 414 leukemic patients which correspond well with our personal experience at Ohio State. The National Cancer Institute found that 31 per cent of the significant infections were due to *Pseudomonas*. The second largest group was fungal infections. In recent years these have been on the increase and now approximately 23 per cent of the patients with leukemia develop fungal infections. The third most common organism category is *Klebsiella*. This is followed by *E. coli*, *Proteus*, and *Staphylococcus* which is usually resistant to penicillin.

It is very important to obtain a specific diagnosis of the infection by culture. Antibiotic therapy, however, is often instigated before the culture results are back, due to the serious nature of complicating infection in leukemia. I now use Coly-Mycin® and Keflin® initially until the culture and sensitivities can pinpoint the therapy further. Coly-Mycin is nephrotoxic; therefore the urinary output and blood urea nitrogen should be periodically checked. Keflin has fewer side effects. One must also be aware of thrombophlebitis developing at the site of local injection.

Fungal Infections

The etiology of the pulmonary infectious process in this patient remain obscure. It may have been bacterial or fungal. Perhaps it was related to the monilial lesions in the mouth. Another possibility is that this was a leukemic infiltration of the lungs with a superimposed infection. Because it developed so rapidly, I don't think this is a possibility, and I will say that the most likely diagnosis to me in this case is a fungal infection. But what type of fungal infection? What is the incidence of each type of fungus in patients with acute leukemia who die with a fungal infection? According to the National Cancer Institute report, the most common fungal organisms were *Candida*, *Aspergillus*, *Mucor*, and *Cryptococcus*, in that order. I believe we find *Cryptococcus* more commonly in our series, so I would tend to favor this organism.

Well, you wonder why if we feel this way we didn't treat this patient for fungal infection. Although amphotericin is toxic, I often feel we should start this therapy before a positive etiologic diagnosis is obtained in those patients with presumptive clinical evidence of mycotic infection.

Perhaps I should comment upon the history of possible fowl leukosis in the environmental background of our patient. I am extremely interested in, and at present am investigating, viruses as a cause of leukemia. Certainly viruses have been established as etiologic factors in some neoplasms. Fortunately the virus that causes fowl leukosis is not transmissible to humans.

DR. WEISSLER: Aren't there some characteristics

on chest x-rays that would help to distinguish the type of fungal diseases? For example, does cryptococcosis tend to involve certain areas of the lung-fields? Does it tend to be more migratory? Does it change in appearance in a few days?

DR. HARRIS: Most of the cryptococcosis we have seen has nonspecific lesions commonly with neurological manifestations, which this patient apparently did not have. It does, however, tend to be somewhat more commonly located in the upper lobe and has rapid changes in size or shape.

CLINICAL DIAGNOSIS

1. Acute monoblastic leukemia.
2. Mycotic pneumonia, probably *Cryptococcus*.

PATHOLOGIC DIAGNOSIS

1. Acute monoblastic leukemia.
2. Disseminated mucormycosis.
3. Widespread mycotic thrombi.

DISCUSSION OF THE PATHOLOGY

DR. CUPPAGE: This was, as diagnosed, acute monoblastic leukemia. At autopsy the bone marrow contained many monoblastic and monocytic cells as we saw in the peripheral smear; however, it is very difficult to adequately examine these cells under this type of preparation, after decalcifying or squeezing the specimen, embedding in paraffin, and staining with hematoxylin and eosin. The antemortem smear really gave us the diagnosis. The only place that we could really identify leukemic cells at autopsy was in the spleen, which weighed 460 Gm. It contained leukemic infiltration and focal infarcts related to the presence of intravascular thrombi. The lack of evident widespread leukemic infiltration in this patient is likely related to the fact that he had had such rigorous therapy.

The lungs contained some very interesting findings. They were heavy, weighing 1400 and 1300 Gm. They contained consolidated pneumonia involving all portions of both lungs but mainly the lower lobes. Very few mature polymorphonuclear leukocytes were seen in these hemorrhagic areas of consolidation. This was essentially an agranulocytic fungal pneumonia. The numerous fungal organisms were evident within the septa and alveoli. The individual fungal hyphae were irregular and measured up to 20 microns in diameter. They were nonseptate and branching. The fungus, characteristic of mucormycosis, was abundant within thrombi in the lumens of many blood vessels and was seen extending through the vessel walls. This organism has a propensity to grow within the blood-vascular system, to become lodged within and incite the formation of a thrombus, and to then extend through a relatively normal blood vessel wall into the adjacent tissues causing an inflammatory reaction. Thrombi were identified within both small and large major vessels of the lungs. Infarcts of varying size were

evident within the pulmonary parenchyma supplied by these thrombosed vessels. This is a common finding in mucormycosis because of this propensity to cause intravascular thrombosis.

The appendix was also involved in this case of widespread, disseminated mucormycosis. The appendix was ruptured and an associated acute periappendicitis had developed. The infection extended into the overlying anterior abdominal wall. Again, appendiceal thrombosis associated with the organism may have been an underlying factor in the rupture of this organ.

The kidneys were also involved with mucormycosis. Hyphae-containing thrombi were present within many

blood vessels. There were resulting infarcts and acute mycotic pyelonephritis.

I would describe this as a typical case of mucormycosis. The organisms often cause disease in patients with diabetes mellitus or neoplasia. The organisms are large, nonseptate, branched hyphae and they grow within blood vessels, causing thrombosis and infarction in many of the organs throughout the body. The organisms are able to gain a foothold in a patient such as this in part because of the lack of mature leukocytes to combat the organisms. In this instance, as is often the case, chemotherapy likely played a role in decreasing host resistance.

MANAGEMENT OF OSTEOMYELITIS. — Only the early institution of adequate antibiotic treatment for acute hematogenous osteomyelitis can prevent bone sequestration and chronic disease. The diagnosis cannot wait for development of x-ray changes, because it takes at least 10 days before localized demineralization of bone and periosteal new bone formation can be demonstrated. Any child with a temperature elevation and tenderness over a bone with some swelling, pain, and perhaps erythema has acute hematogenous osteomyelitis, and only rarely must one rule out recent fracture, rheumatic fever, poliomyelitis, cellulitis, and thrombophlebitis. It is better to err on the side of overtreatment than inadequate treatment.

If osteomyelitis is suspected, the child should have two blood cultures at 20-minute intervals and the tender area should be aspirated. The pus (or the needle if no pus is found) should be sent for culture, and sensitivities to penicillin and other bactericidal antibiotics should be determined. The child should be started immediately on adequate doses of appropriate antibiotics. In order to cover penicillin-resistant and penicillin-sensitive staphylococci, one may use methicillin with penicillin, sodium nafcillin with penicillin, or lincomycin (lincomycin hydrochloride monohydrate, Lincocin®) alone. Because of the seriousness of the infection and the importance of high blood levels, the author favors using two to four times the recommended dosage of these drugs. After the culture and sensitivities are reported, the inappropriate drug may be discontinued.

Antibiotic therapy can be considered adequate only if the patient receives the appropriate antibiotic for one month after he has become afebrile and has a normal sedimentation rate, or after the wound ceases to drain in cases where incision and drainage have been performed. — A. Bill Kieger, M. D., Ann Arbor, Mich.: *University of Michigan Medical Center Journal*, 31:180-181 (July-Aug.) 1965.



NEWS AND *Organization Section*

Proceedings of The Council...

Matters Considered and Actions Taken at Feb. 18-19 Meeting;
Policies Adopted Regarding Government Medical Care Programs

A REGULAR MEETING of The Council of the Ohio State Medical Association was held in the headquarters office, Columbus, February 18-19, 1967. Those present were: Drs. Lawrence C. Meredith, Elyria, President; Robert E. Howard, Cincinnati, President-Elect; Henry A. Crawford, Cleveland, Past President; Philip B. Hardymon, Columbus, Treasurer; Paul N. Ivins, Hamilton; Theodore L. Light, Dayton; Frederick T. Merchant, Marion; Robert N. Smith, Toledo; P. John Robeck, Cleveland; Edwin R. Westbrook, Warren; Sanford Press, Steubenville; Robert C. Beardsley, Zanesville, Oscar W. Clarke, Gallipolis; Richard L. Fulton, Columbus; William R. Schultz, Wooster, District Councilors. Others attending the meeting were: Mr. Wayne E. Stichter, Toledo, OSMA Legal Counsel; Mr. Roger Smith, Offices of the General Counsel, Toledo; Dr. Perry R. Ayres, Columbus, Editor, *The Ohio State Medical Journal*; Mr. David B. Weihaupt, Chicago, AMA Field Representative; Dr. John H. Budd, Cleveland, Chairman, Ohio delegation to AMA; Dr. Robert E. Tschantz, Canton; Dr. H. William Porterfield, Columbus; Dr. Edmond K. Yantes, Wilmington; Mr. James S. Imboden, Columbus, Field Representative, American Medical Political Action Committee; Messrs. Page, Edgar, Gillen, Traphagan, Campbell, and Moore of the OSMA staff.

In Memoriam

The Council paid tribute to the memories of Dr. George W. Hamwi, Columbus, and Dr. Carl S. Mundy, Toledo.

Minutes Approved

The minutes of the meeting of The Council held December 10-11, 1966 were approved by official action.

Membership Statistics

Mr. Page presented membership statistics as follows: OSMA membership as of February 17, 1967, was 6,709, compared to a total membership of 6,303 on February 17, 1966. Of the 6,709 members, 5,727 were affiliated with the AMA.

Reports by Councilors

The Councilors reported on activities in their districts.

Opinion on Review of Fees

The Council directed that the following communication be sent to Dr. Raymond J. Thabet, Mansfield, Ohio, in reply to his letter of inquiry dated February 16, 1967:

"This is to acknowledge your letter of February 16, 1967, in which you request advice as to the propriety of a review of a physician's fees by a hospital medical staff advisory committee.

"This matter was thoroughly considered at a meeting of The Council February 18, 1967. The Council forthwith issued the following statement:

"It is proper for the physician to establish the fee which he charges to any patient for the professional service rendered, with recognition of the fact that a duly constituted County Medical Society committee of his peers may appropriately review and pass upon the equity and justice of his charge. It is not proper for hospital management nor a hospital medical staff to attempt to exercise this function."

"Neither the hospital management nor the hospital medical staff has the privilege or the right to demand an audit of staff members'

personal financial records for any purpose. Any such attempt on the part of the medical staff to compel such audit is unethical."

The Council also directed that a copy of its letter be mailed to the Richland County Medical Society.

1967 Annual Meeting

Mr. Traphagan presented a progress report on the 1967 Annual Meeting to be held in Columbus, May 16-19.

The Council authorized the Committee on Scientific Work to invite a staff member of the Federal Food and Drug Administration to replace Dr. James L. Goddard, Washington, D.C., Commissioner, Food and Drug Administration, who will be unable to participate in a panel discussion on compulsory generic prescribing at the general session on Thursday, May 18. It was indicated by The Council that if a staff member could not be obtained the committee might invite Senator Russell Long, Louisiana.

The Council authorized special rates for medical students, interns, and residents who wish to bring their wives or "dates" to the Gaslight Party on Thursday, May 18.

In lieu of publishing the complete annual meeting program in *The Ohio State Medical Journal*, The Council directed the Committee on Scientific Work and the staff to publish a complete program booklet well in advance of the meeting and that a copy be mailed to each member of the Ohio State Medical Association.

Annual meeting resolutions from Franklin and Mahoning Counties were presented by the Executive Secretary for the information of The Council.

Workmen's Compensation

The Council officially noted the publication of a fee schedule for radiologists issued by the Bureau of Workmen's Compensation on January 26, 1967, the rescinding of such fee schedule and the return to the usual and customary fee principle by the Bureau on February 3, 1967, due to the efforts of the Ohio State Radiological Society and the Ohio State Medical Association.

The Council voted active support of the principle in proposed legislation for a competitive system in providing workmen's compensation insurance, if amendments suggested by The Council of the Ohio State Medical Association are adopted.

AMA House of Delegates

The Council approved the following resolutions for introduction at the June, 1967 meeting of the AMA House of Delegates:

"Late" Submission of Resolutions

WHEREAS, The provision for unanimous consent to permit the House of Delegates of the American Medical Association to accept a "late" resolu-

tion allows one delegate to stand in the way of an introduction of a resolution; and

WHEREAS, Such a provision permits one man to block consideration of an idea or philosophy which might be of immense importance to the members of the medical profession; and

WHEREAS, The present policy does not conform to the principles of Roberts Rules of Order; therefore be it

RESOLVED, that the Constitution and Bylaws of the American Medical Association be amended to permit the acceptance of a late resolution by two-thirds consent of those members of the House of Delegates present.

Early Submission of Reports and Resolutions

WHEREAS, Only 13 reports of the Board of Trustees, the Councils, and Committees of the AMA were available prior to the 1966 Clinical Session; and

WHEREAS, Twenty-two additional reports from the Board, Councils and Committees were issued to the delegates during the 1966 Clinical Session; and

WHEREAS, The House of Delegates received 40 resolutions during the session, in addition to the 24 which appeared in the Handbook; and

WHEREAS, Such delay in receiving reports and resolutions makes it difficult for the delegates to give the necessary consideration to these materials; therefore be it

RESOLVED, That the Councils and Committees of the American Medical Association meet sufficiently in advance of the midyear and annual sessions of the House, so that their reports may be in the delegate's packet for study prior to the opening of the convention; and be it further

RESOLVED, That the House of Delegates insist that reports already completed by the Board of Trustees, the Councils, and Committees be included in the delegate's handbook or forwarded to them in advance and not withheld until the midyear or annual meeting is in session; and be it further

RESOLVED, That all delegations be encouraged to submit their resolutions as early as possible.

A suggestion for a possible additional resolution on the Millis report was received by The Council.

Statements by AMA President

Communications from the Ross County Medical Society and several individual physicians concerning statements to the news media by the President of the American Medical Association were discussed by The Council. By official action, The Council referred the Ross County Medical Society communications to the American Medical Association, and instructed that correspondence between the President of the Ohio State Medical Association and the President of the American Medical Association on

this matter be published in *The Ohio State Medical Journal*.

Committee on Nursing Appointed

The Council approved a request by the President for the establishment of a special committee on nursing of the Ohio State Medical Association. Subsequently, the following appointments to this committee by the President were ratified by The Council: William J. Lewis, M.D., Dayton, Chairman; Lloyd E. Larrick, M.D., Cincinnati; Maurice F. Lieber, M.D., Canton; Irving A. Nickerson, M.D., Granville; Anthony Ruppertsberg, Jr., M.D., Columbus; Margaret J. Schneider, M.D., Cincinnati; Jeanne H. Stephens, M.D., Oberlin; J. H. "Hutch" Williams, M.D., Columbus.

Ohio Medical Indemnity, Inc.

A report of the liaison committee of Ohio Medical Indemnity, Inc., was presented by its chairman, Dr. Robert E. Tschantz, Canton, and was approved by official action of The Council.

Dr. Yantes discussed the Toledo program on billing for anesthesiology services. It was suggested by The Council that Ohio Medical Indemnity, Inc. give this matter further study.

A resolution from the Ohio State Radiological Society with regard to the matter of hospital service association policies containing provisions covering professional services of physicians was brought before The Council. The Council stated that it is sympathetic to this resolution and that it is working in definitive ways to solve this problem.

In accordance with House of Delegates Substitute Resolution 16 (1966) and at the instruction of The Council, representatives of the Ohio State Medical Association on the Ohio Hospitalization Benefits Committee will bring to the attention of that committee the difficulties engendered by constant encroachments by prepaid hospital insurance plans into the field of coverages for professional services of physicians.

Amendment to Trumbull County Constitution

A proposed amendment to the constitution of the Trumbull County Medical Society, changing the percentage of active members who shall constitute a quorum from 25 per cent to 15 per cent, was approved.

Cleveland Academy of Medicine

A request from the Cleveland Academy of Medicine for a reduction in OSMA dues for three members was considered by The Council.

The Executive Secretary was instructed to provide the Cleveland Academy of Medicine with a copy of the provision of the OSMA Bylaws which provide that "If the society, or the council of the society, finds that payment by such member of his regular

dues in this Association shall constitute a financial hardship and certifies such finding to The Council . . . The Council will make such adjustment of his OSMA dues for such period of time, etc."

Summit County Communication

In answer to a communication from the Summit County Medical Society, dated December 7, 1966, The Council instructed the Executive Secretary to advise such society that the Association is not in a position to provide legal counsel to individual members of the Ohio State Medical Association.

With regard to a second part of the communication, requesting a portion of State Association dues for Summit County Medical Society programs, The Council by official action voted to reject such proposal.

Cincinnati Academy of Medicine

In reply to a letter from the Cincinnati Academy of Medicine, The Council advised that as long as county societies tender OSMA and AMA dues at a stated time, the time of the collection of county medical society dues remains within the province of the local society and in accordance with the provisions of its constitution and bylaws. Chapter 2, Section 1 of the OSMA Bylaws, states that "dues shall be payable before January 1 of the calendar year for which such dues are levied . . ." and Section 3 of Chapter 2 specifies that a member of this Association shall be deemed delinquent and in arrears in all his relationships as a member from and during the period extending from January 1 of the current year until his dues and assessments shall have been received. . . ."

Meigs County Hospitals

Dr. Clarke discussed developments with regard to staff problems in Meigs County Hospital.

The Council instructed Mr. Stichter to draft a statement involving an interpretation of No. 7 of Section 3 of the Code of Medical Ethics of the American Medical Association as reported in the Judicial Council Opinions and Reports, 1966, such statement to be forwarded on behalf of The Council to the Meigs County Medical Society.

Washington Visit

The Council discussed the proposed visit by OSMA representatives to congressmen in Washington, D.C., April 12, 1967. It was suggested that such delegation should be made up of the OSMA Committee on Legislation, Officers, and Councilors, chairman of the Committee on Government Medical Programs, chairman of the OSMA delegation to the AMA, and members of the OSMA staff.

Federal Legislation

Mr. Edgar reported on federal legislation introduced or expected to be introduced in the Congress. He said there were many proposed amendments to Medicare, including extending coverage, eliminat-

ing deductibles, establishing a Part C for hospital-based physicians and out-patient services, eliminating the requirement for a receipted bill, adding optometric services, adding drug benefits, generic prescribing, and others. Also, the President has proposed a Social Security tax and wage base increase to cover costs of the additional benefits.

Mr. Edgar reported that Senator Hart's Bill, S. B. 260, to prohibit physicians from indirectly or directly selling drugs or devices, or owning a legal, beneficial, or leasehold interest in a community pharmacy or optical dispensary, drug company or drug repackaging house, was being heard by the Senate Subcommittee on Anti-Trust and Monopoly, and that the AMA would present opposition testimony February 21.

The Council instructed the Executive Secretary to direct a letter of inquiry to the American Medical Association with regard to specific action being taken on federal legislative proposals.

Compulsory Generic Prescribing

The Council discussed current proposals for compulsory generic prescribing in the case of patients who are receiving federal money in connection with their health and medical care. By official action, The Council endorsed the policy of the AMA House of Delegates adopted at the 1966 clinical session.

The House, in approving the recommendation of Reference Committee E, accepted Report N of the Board of Trustees and adopted these recommendations:

"1. Reaffirm the present policy of the Association which states that physicians should be free to use either the generic or the brand name in prescribing drugs for their patients; and

"2. Encourage physicians to supplement medical judgments with cost consideration in making this choice."

Direct Billing

A statement on implementation of the OSMA direct billing policy as developed by an ad hoc committee, was amended and adopted as follows:

In order to preserve the independence of the medical profession, the Ohio State Medical Association has prepared this suggested implementation of the Ohio State Medical Association's direct billing policy.

Direct billing is the sole method by which practicing physicians . . . Ohio Physicians . . . can preserve and fight for the independence of the medical profession, and, if the physician values this independence, he should resist any attempt by any third party—governmental or non-governmental—to insert itself into this relationship. The physician is urged to deal directly with his patient to whom his responsibility must be foremost, as directed by his oath as a physician

and the principles of medical ethics. This is the method which best gives evidence of the physician's responsibility and relationship with his patient.

The House of Delegates of the American Medical Association adopted the policy, in November 1966, that hospital-based physicians should bill patients directly for their services as indicated in the acceptance by the House of Delegates Resolution Number 16. It is obvious that this direct billing policy should apply to every physician regardless of the type of practice.

Direct billing means the preparation of a separate bill for professional services on the physician's own letterhead (or billhead), addressed and delivered to the patient. It is essential that the physician have no arrangement or understanding with the patient which would have the effect of relieving the patient of his responsibility to the physician for payment for services rendered. When initiating a program of Direct Billing, the following steps should be observed:

1. Having performed a professional medical service for any patient, the physician bills the patient (or other person such as parent, spouse, or guardian who has contracted directly with the physician for payment of such professional services) informing the patient that the physician looks solely to him for payment of the bill.

2. If the patient expects to be reimbursed by any third party, the patient should complete the "patient portion" of the "claim form" required and the physician should provide such medical information as may be reasonably required by the third party.

When the physician follows this procedure, he should regard it as his policy for any and all third parties.

Further, the physician should take steps to inform his patient of his intention to implement this program and his reasons for doing so.

Communications and Conferences

Mr. Edgar reported on meetings with representatives of the Social Security Administration, Nationwide Insurance Company and Ohio Department of Public Welfare on January 4 and January 8, 1967 with the officers of the OSMA and President of the AMA. Presented in connection with the report was a letter from Mr. Arthur E. Hess, Director, Bureau of Health Insurance, Department of Health, Education, and Welfare, to Dr. Meredith, commenting on the meeting of January 8.

Also studied by The Council was a suggested letter developed by the Department of Public Welfare to be sent to the physicians in Ohio; a letter dated December 13, 1966 from the Franklin County Welfare Department to all Medicare recipients in

Ohio; a letter from Robert B. Canary, Assistant Director, Ohio Department of Public Welfare, dated February 7, 1967; a letter dated January 25, 1967, from the president of the Indiana State Medical Association to all members of that Association; and a communication dated December 15, 1966, from the Ohio Society of Internal Medicine to the Ohio State Medical Association, endorsing the position of the OSMA regarding direct billing.

Present Policy To Continue

By official action, The Council voted to continue its present policy on direct billing; to inform those attending the county society officers conference regarding its policy; and to request the District Councilors to inform the county medical societies of this action and current developments in this program.

State Welfare Department

Dr. Meredith and the Executive Secretary reported on a conference February 1, 1967, with John McElroy, Assistant Governor of Ohio, with regard to the problems of physicians in programs of the Department of Public Welfare.

The Council instructed the President to direct a letter to Mr. Robert Canary, Assistant Director of the Ohio Department of Public Welfare, commenting on Mr. Canary's remarks in a letter of February 7, 1967 to Mr. Thomas Brittenham, Director, Franklin County Welfare Department. It was Council's opinion that the Governor of Ohio should receive a copy of this correspondence.

State Legislation

Medical Practice Act Revision

The Council approved the draft of a bill to amend the Medical Practice Act.

Clarification of Podiatry Statutes

The Council voted to sponsor legislation to clarify the provisions in the podiatry sections of the Medical Practice Act by specifying that podiatrists are permitted to use only local antiseptic preparations, local anesthetics, local analgesics, local antibiotics, and local steroids.

Proposed Podiatry Bill

A bill which has been proposed by the Ohio Podiatry Association was reviewed. The Council voted to actively oppose the bill as submitted.

Experimental Drugs

The Council voted to sponsor, in cooperation with the Academy of Medicine of Cleveland, a bill to restrict the use of experimental drugs in human investigation, with the preferred method of accomplishing this procedure being the deletion of paragraph 1 of Subsection C of Section 3715.65 of the Ohio Revised Code.

Abortion Reform Legislation

The Council voted to support, in principle, legislation providing for abortion law reform in Ohio;

and in the event the Academy of Medicine of Cleveland desires to sponsor such legislation, to make available to the Academy the benefit of studies of this legislation by Mr. Wayne E. Stichter, OSMA legal counsel.

Mandatory Nurse Licensure

The proposed bill submitted by the Ohio State Nurses Association with regard to mandatory nurse licensure was reviewed by The Council. The Council expressed an opinion that there were a number of objectionable features in this bill and voted to actively oppose it if introduced.

Retardation Legislation

The Council reaffirmed its support of legislation with regard to statutory autonomy for retardation as expressed in House Bill 567 at the 1965 Ohio General Assembly.

Disposition of Bodies

The Council endorsed, in general, legislation to provide for the gift of bodies and parts of bodies to medical and educational institutions.

Laboratory Legislation

A proposal from the Ohio Society of Pathology with regard to the licensing of clinical laboratories was referred to the Committee on Laboratory Medicine for study.

Medical Records

The Council voted to sponsor a bill providing for the confidential character of medical studies conducted by the Ohio State Medical Association and allied organizations.

Utilization Committees

The Council voted to sponsor legislation which would provide a physician who serves on utilization review committees immunity from litigation arising from the actions of the committees.

Isolation of Patients Having Tuberculosis

The Council voted support of S.B. 32 to provide for the examination of persons suspected of having tuberculosis in a communicable stage.

Proposed Blood Alcohol Bill

The Council voted to support, in principle, a proposal concerning the alcoholic content of blood in operators of motor vehicles; and the principle of implied consent of Ohio licensed drivers to a chemical test of blood, breath, urine, or saliva for the purpose of determining alcoholic content of the blood.

Licensing of Hearing Aid Dealers

A bill to provide for the licensing of hearing aid dealers H.B. 106, was found by The Council to be objectionable in its present form.

Re-examination of Drivers

The Council voted to oppose the principle of legislation which would provide for the re-examination of all drivers for licensing every six years.

Committee on Cancer

Mr. Traphagan presented the minutes of the January 26 meeting of the Committee on Cancer.

Papanicolaou Smears

A statement on Papanicolaou smears was amended to read as follows:

... it is desirable that pap smears be performed on all married females and all other females over 21 years of age, upon admission to the hospital." It is the understanding of The Council that before hospital staffs adopt this recommendation, procedures will be established so that repeat pap smears will not be necessary if the patient had had one performed within the previous six months."

Rand Vaccine

It was the recommendation of the committee that The Council approve the report of the Academy of Medicine of Cleveland by a special committee appointed to investigate testing procedures of the Rand Cancer "Vaccine." The text of the report is as follows:

REPORT TO THE ACADEMY OF MEDICINE OF CLEVELAND

By the Special Committee Appointed to Investigate Testing Procedures of the Rand Cancer "Vaccine"

On August 19, 1966, an article appeared in The Cleveland Plain Dealer concerning a cancer "vaccine" being developed by the Rand Corporation and being made available for use in humans on an experimental basis. This article was written by the financial editor of The Plain Dealer and was prominently displayed on the front page. The news story was picked up by other news media and received widespread publicity.

Following this publicity, many physicians in the community were asked to evaluate the Rand "vaccine" for use in patients without having any factual information on which to make a judgment. Because of this and because the Academy of Medicine has been concerned about the ethics of human experimentation, Mr. Rand was invited to a special meeting of the Board of the Academy of Medicine so as to provide the Board with more factual information. Mr. Rand willingly acceded to this meeting which took place on October 18th. Also present at this meeting were Mr. Rand's attorney, Mr. Trenkamp; Mr. Lewis, Head of Cancer Research at the Rand Corporation; and Doctors Cahill (M.D.) and Medina (M.D.) who were actively involved in the clinical investigation of the material.

The following points were elicited:

1. There have been no experiments with animal tumors to test the efficacy of the "vaccine". There have been no presentations at scientific assemblies, no publications and no critical review or evaluation of data. The Rand Corporation does not have, at this time, essential data establishing the specificity of the tumor antigens being employed, the production of specific antibodies against the tumor antigens and the lack of cross-reaction with normal tissue antigens.

2. Experiments of toxic or other side effects have been performed on only one horse, twelve rabbits, and forty mice for a "minimum of three injections."

3. The "vaccine" is being administered to human beings without meeting the requirements of federal laws applicable to experimental biological drugs. Federal law stipulates the requirements that a new drug must meet before either the Food and Drug Administration or the Division of Biological Standards of the Federal Government will permit shipment in interstate commerce. Most pharmaceutical concerns meet these requirements, even for intrastate shipments. The application of the Rand Corporation for approval by federal agencies of the "vaccine" for interstate shipment has been deemed incomplete and the Rand Corporation has been forbidden interstate shipment of the "vaccine". Mr. Rand and his colleagues state that the Division of Biological Standards is awaiting more experimental data.

4. The human experiments being performed cannot be expected to demonstrate the efficacy of the "vaccine". No controls or double blind studies are being employed. The material is being released to any licensed physician (M.D.) and osteopaths requesting supplies of the "vaccine" without regard for his experience in clinical investigation and without regard to proposed methods of determining the effect of the vaccine. The best that can be expected from such experiments is a series of uncritical anecdotal accounts without scientific value.

The Committee is aware that an immunologic approach to cancer merits investigation and that many experienced investigators throughout the world are pursuing this matter diligently and in the systemic manner which the scientific community expects.

The Rand "vaccine," however, has not been subjected to the preliminary, scientific research and testing deemed proper by the American Medical Association, by most pharmaceutical concerns and other research institutions and under federal law by federal drug agencies before human experimentation is attempted. It is, therefore, the opinion of this Committee that the use of the Rand "vaccine" in human beings at the present time is completely unwarranted.

The Committee makes the following recommendations:

1. That the Rand Corporation should be urged to withdraw its "vaccine" voluntarily and discontinue all further human experiments with this agent until further investigative and research data are available.

2. That the facts be published in the Bulletin of the Academy of Medicine and that they be made available to the news media.

3. That the Committee, in conjunction with the Ohio State Medical Association, sponsor state legislation comparable to federal laws, requiring a review of scientific data and adequate animal testing before permitting investigational use of drugs, vaccines, or any other biological material in human beings in the State of Ohio.

4. That negative results which have been accumulating be published.

Presented by:

William F. Boukalik, M.D.

Henry A. Crawford, M.D.

J. Beach Hazard, M.D.

Alan R. Moritz, M.D.

Leo Walzer, M.D.

Austin S. Weisberger, M.D., Chairman

The Council approved the recommendation of the committee that:

"1. The report of the special committee of the Academy of Medicine of Cleveland be approved and endorsed and that the recommendations made within the report be approved by The Council of the Ohio State Medical Association.

"2. That the Ohio State Medical Association extend its thanks and congratulations to the spe-

(Continued on Page 513)

cial committee to the Cleveland Academy and to its chairman Dr. Austin S. Weisberger for the thoroughness and excellence of its report."

The minutes of the meeting of the Committee on Cancer as a whole were approved by The Council.

Legal Matter

With regard to a request from Mr. Charles J. Chastang, Columbus attorney, that the Ohio State Medical Association file a brief amicus curiae in the Supreme Court in a pending legal case urging the Supreme Court to take jurisdiction, it was the decision of The Council not to file such a brief at this time. If the motion to certify is allowed by that court, Mr. Stichter was authorized to file a brief on behalf of the Ohio State Medical Association if, in his judgment, such procedure is advisable.

Ohio State Society of Medical Assistants

Concerning a request from the Ohio State Society of Medical Assistants, the Executive Secretary was authorized to provide certain mailing assistance to make it possible for the society to send a copy of the current issue of its bulletin to all members of the Ohio State Medical Association, subject to a review and approval of the material to be mailed. The President was authorized to review the material in question.

Committee on Government Medical Care Programs

The Council, by official action, amended and adopted policies recommended by the Committee on Government Medical Care Programs. The policy statements as amended, are contained in the following passages:

In Regard to Ohio Welfare Budget

1. That OSMA take appropriate steps to inform county medical society legislative chairmen of the need for an increase in the budget of the Ohio Department of Public Welfare, and of the approximate amount of increase needed, and recommend that these chairmen make contact with members of the Ohio House of Representatives and Ohio Senate from their areas regarding legislative support for such an increase in the Ohio Department of Public Welfare Budget.

2. That the Ohio Department of Public Welfare develop a brochure which would explain the role and responsibility of the physician with regard to each of the four public assistance programs. This recommendation is made with the knowledge that most physicians although somewhat knowledgeable about the Aid for Aged program are not familiar with the operation of the Aid for Blind, Dependent Children, and Disabled programs.

Appalachia and Demonstration Health Facilities (Sec. 202, Appalachia Act)

It was noted that the recommendations of the Appalachian Liaison Committee, chaired by Dr. Tschantz, had been approved at the December 10-11, 1966 meeting of The Council.

In view of the policy previously established, and further deliberations of the Committee, The Council approved its recommendations as follows:

Preamble

"It must be admitted that neither organized medicine, the states, nor the various communities have accepted the challenge of leadership in this vital area, thus creating a gap or vacuum into which the federal government is moving. The process of creative federalism is already at work. The medical profession has an innate responsibility in the implementation and operation of the facilities, and with the acceptance of these responsibilities should be entitled to the privilege of adequate representation on national, state, and local bodies which determine policy, authorize expenditures, and direct the various phases of these public health projects." (From White Paper on Appalachia—1966, West Virginia State Medical Association)

Be it Resolved:

1. That a representative (practicing physician) from each County Medical Society included in the plan of the Ohio Valley Health Service Foundation, Inc., be a voting member of the Board of the Ohio Valley Health Service Foundation and that, in the future, any areas engaged in Demonstration Health Facility Planning included at the top level of organization, a representative (practicing physician) from each county medical society involved in the plan.

2. Small county medical societies be allowed to combine into multicounty societies so that more medical leadership be provided in planning groups.

3. That legislation be sought to combine local county health departments into multicounty health departments so that more services may be given and this kept on a local, rather than a national level.

4. That recommendations of the OSMA Appalachian Liaison Committee, approved by The Council in December, be vigorously supported and the plans of the Ohio Valley Health Service Foundation, Inc. be carefully scrutinized in light of these recommendations so that OSMA policy will be adhered to.

Bureau of Vocational Rehabilitation

Regarding the program of the Bureau of Vocational Rehabilitation, it was resolved:

1. That an educational campaign be conducted among physicians by the Ohio State Medical Asso-

ciation to encourage referral of patients for rehabilitation.

2. That the Ohio State Medical Association support an increased appropriation by the State for the Bureau of Vocational Rehabilitation.

3. That the Ohio State Medical Association have a close continuing relationship with the Bureau of Vocational Rehabilitation through the Committee on Government Medical Care Programs.

4. That the Ohio State Medical Association pursue the adoption by the Bureau of Vocational Rehabilitation of the principle of payment of the physician's usual, customary, and reasonable fees.

5. That various reports regarding patients being treated under this program be made from the attending physician to the Field Medical Consultant and not to lay administrators, in order to protect confidentiality of physician-patient relationships.

6. That an appeal be made to the Bureau requesting that a physician be appointed to the Ohio Council on Vocational Rehabilitation.

Comprehensive Health Planning (PL 89-749)

1. Regarding PL. 89-749 (Comprehensive Health Planning), there be a state-wide approach to planning rather than regional with the OSMA playing a large role in the state-wide aspect, through the Committee on Government Medical Care Programs.

2. That the OSMA recommend to the agency designee that an advisory committee be appointed to receive applications from local groups, to evaluate them and to establish priorities; this committee to include adequate physician representation appointed from a list supplied by the Ohio State Medical Association.

It was reported that the Ohio Department of Health has been appointed the designee agency in Ohio by Governor Rhodes.

3. That local planning groups include adequate representation from all county medical societies involved in an individual plan.

4. That the Ohio State Medical Association, county medical societies, and individual physicians contact congressmen from Ohio to request that additional funding for this program be held up until the Act is changed to reduce or eliminate the potential danger to the practice of medicine and until an adequate role of physicians in the planning is established.

5. With regard to physician's fees, that the OSMA policy regarding the physician's right to bill his patients directly on the basis of his usual and customary fee be maintained in this program.

6. If "centers" or "clinics" are established in connection with this program a "sliding scale" of charges for technical and administrative services be established so that the citizen who may be well able

to pay for his health care will be discouraged from using services of the "center."

7. That the operation of Comprehensive Health Planning Services must not infringe upon the private practice of medicine.

Conference on PL 89-749

For additional information on this subject, Mr. Gillen reported on a conference involving Dr. Meredith, Dr. Emmett Arnold, Ohio Director of Health, and Messrs. Page and Gillen with regard to PL 89-749, Comprehensive Health Planning program.

In Regard to Crippled Children's Program

1. In the opinion of The Council the Crippled Children's program, under the present direction of Dr. Elizabeth Aplin, has expanded appropriately to meet the challenge of need, and is doing a fine job.

2. It is noted that the total program is a constructive one, devoted primarily to the acceptance of children who have a reasonable outlook of some degree of complete rehabilitation, rather than just care of disabled children. It is not that the care of disabled children is unrealistic, but that this care should remain the province of other departments and the primary aim of rehabilitation of children remain with the Crippled Children's Service.

3. At the present time, short and long lasting illnesses or handicaps that threaten the financial future of the family, fit into the program. These basic reasons for accepting children into the Crippled Children's Service appear appropriate and should be continued.

4. Since the care of the child is the responsibility of the physician and the child's parents, it would appear appropriate to have the parents of the patient request help from the Crippled Children's Service. In this way the contract for medical and monetary assistance would reside properly with the parents since they are the ones seeking assistance. In this way two separate contracts would be consummated. The first, would be a contract between the child's parents and the physician for the rendering of medical care. The second, would be a contract between the child's parents and the Crippled Children's Service for monetary assistance in paying for this care.

5. At present resident physician care for children is permitted in the hospital or clinic providing the resident and the child are under the direction of an accepted specialist. Inasmuch as these patients are not charity patients. The Council sees no reason to alter this, providing the patient be treated properly as a private patient of the physician in charge.

6. At present no clinic or hospital as such is granted the right to care for crippled children in this

program. This decision is based on the fact that there may be changes in resident and/or institutional physicians and therefore continuity of care may be lost. The Crippled Children's Service does not pay clinics for the care of its patients. The child is considered the private patient of the doctor approved by the program for the patient at the time of the acceptance of the application. This arrangement appears satisfactory and should be continued.

7. In setting up a budget for the family in question concerning the monetary help they need, the resource of the family, including health insurance that they may have, is taken into account. Then the estimate of the total cost is made and the Crippled Children's Service adds to this the amount of money estimated to be needed to complete the rehabilitation. Since the monetary contract for help should be made between the parents of the patient and the Crippled Children's Service, it would seem appropriate for the payment to go back to the parents and thence to the physician. It is thought that this is a proper procedure both from the contract arrangements standpoint and the fact that the parents would then realize the value of the service that is being paid for.

8. At present all medical, hospital, and other fees are paid on a contract basis. Each Ohio hospital is required to submit an annual audit to the State Department of Health. This report is adjusted to take into account the field audit made by the Bureau of Workmen's Compensation. A per diem cost is then certified by the Health Department to the Bureau of Motor Vehicles and to the State Department of Public Welfare. This then becomes the daily payment that the service will render to hospitals. Physicians are paid on a predetermined fee schedule. This has been necessary in the past because of the monetary limits set upon the program. However, since hospitals are paid on a going daily rate which in effect should be their usual daily rate for the care of any patients, then it would seem reasonable for physicians to be paid their usual fee rather than on a fee schedule. The Council recommends that the necessary money be appropriated to the program to run it on a sound fiscal basis and accomplish all its payments on the usual fee and usual cost basis.

9. Up to now and including the present the Crippled Children's Service has operated some clinics throughout the State. These have been primarily in eastern and southeastern Ohio. They are now in the process of being evaluated and it is the opinion of this committee that such mass screening as it is presently carried out, defeats the purpose of the program. Since the program has propagated the idea that the child is the private patient of a physician, such mass clinic evaluation by any specialists would appear to be defeating the program.

It is recommended that this type of service be discontinued unless specifically desired and approved by the county medical society.

10. The scope of the program in the past has been total rehabilitation to whatever degree is possible. It would seem reasonable at some point in the progress of events, that relinquishing the child in question either to an educational system, prearranged, or to a vocational rehabilitation program, prearranged, would satisfy the ends of this program and then would relieve the Crippled Children's Service of further financial involvement so that their available money could be spent on another child entering the program.

11. At present the crippled children's program takes children to the age of 21. Since aid for the totally disabled begins at age 18, it would appear appropriate for the Crippled Children's Service to refer all of those children who appear to be totally disabled to that service at that age instead of carrying them on until they are 21 years of age. This would effect a monetary savings for this service and avoid duplication.

In Regard to Heart Disease, Cancer, and Stroke

It was resolved:

1. That, for the benefit of Ohio physicians and their patients, methods of communication regarding Heart disease, Cancer, and Stroke programs to physicians and their patients should be expanded. Consideration should be given to using and expanding the Ohio's medical television network to disseminate socio-economic information to professional, paramedical and lay persons throughout Ohio.

2. That there should be maximum utilization of, liaison with and encouragement of other presently existing organizations; medical, paramedical and lay; in Heart Disease, Cancer, and Stroke activities, under the direction of OSMA.

3. That the Ohio State Medical Association should promote and encourage additional programs expanding medical knowledge with regard to heart disease, cancer, and stroke among medical and paramedical personnel in physicians' offices, clinics, and hospitals in Ohio.

4. That the Ohio State Medical Association, its component county medical societies, and individual physicians should be continually alert to the development of programs in the area of heart disease, cancer, and stroke and other government programs and should exert all influence to make certain that all programs are coordinated so that fragmentation is avoided. This alertness and activity will be to the benefit of all involved, patients and physicians.

5. That the Ohio State Medical Association and its component county medical societies and individual physicians should insist on periodic analysis

of all programs in the heart disease, cancer, and stroke area, as well as other government medical care programs, so that "dead wood" in the programs is eliminated and so that procedures are revised to keep up with current problems.

In Regard to Poverty Programs

It was resolved:

1. That a medical report shall determine after discussion with the local welfare agencies, city health nurses, etc., the actual need for these programs. Should this need be determined in the affirmative, the following recommendations should be followed:

a. In any program financed by the Office of Economic Opportunity in an Ohio community there shall be representation at the highest policy level by an official representative of the appropriate county medical society involved.

b. Remuneration for services in above programs is to follow the policies of the Ohio State Medical Association with regard to all financial and contractual relationships.

Regarding Title XVIII

The report of the Subcommittee of P. L. 89-97 presented by Dr. Madsen, chairman, followed by motion duly made, seconded, and carried that the following recommendations as approved be submitted to The Council for approval.

1. That The Council of the Ohio State Medical Association seek introduction by Ohio Congressmen of legislation called for in the following resolution adopted by the House of Delegates of the American Medical Association at the 1966 Clinical Convention in Las Vegas (November 27 - December 1, 1966):

WHEREAS, the Social Security Act makes no specific provision for reimbursing eligible recipients of aid under Title XIX who have paid or wish to pay for their own medical services, and

WHEREAS, this effectively prevents the Title XIX recipients from obtaining care in the same fashion as other members of the community, and

WHEREAS, it actually deprives the Title XIX recipient who is covered under Part B of Title XVIII of the option of direct payment afforded other Title XVIII beneficiaries; therefore be it

RESOLVED, that the American Medical Association strongly support amendment of the Social Security Act including Title 18 to permit payment without assignments for medical care of patients.

2. That The Council of the Ohio State Medical Association seek introduction by Ohio Congressmen of legislation called for in the following resolution adopted by the House of Delegates of the American Medical Association at the 1966 Clinical

Convention in Las Vegas (November 17 - December 1, 1966)):

RESOLVED, That the American Medical Association advise the Department of Health, Education, and Welfare that the present requirements for certification and recertification have proven highly objectionable, unnecessary, and do not contribute to the quality of medical care; and be it further

RESOLVED, That the American Medical Association endeavor to bring about repeal of those portions of P. L. 89-97 in which the requirement for physician certification of medical necessity appears; and be it further

RESOLVED, That the fiscal intermediaries and the American Hospital Association be advised that AMA will be available to assist in the development of appropriate amendments to this legislation. The purpose of this consultation would be to discuss the complexities of this requirement and to invite participation in the development of amendments to the law which will be professionally acceptable and administratively workable.

3. That The Council reaffirm existing policy regarding utilization review committees, as follows:

(1) The function of a utilization review committee is a purely medical function.

(2) The responsibility and obligation of such committees are medical only.

(3) Every utilization review committee shall be composed solely of practicing physicians.

(4) When such a committee enters into an agreement or contract with any third party, the fulfillment of its medical responsibility and obligation is seriously jeopardized.

(5) When a utilization review committee or its individual members accept remuneration for carrying out the medical responsibilities of the committee, an employer-employee relationship is established, which leads to lay influence and control over matters which are strictly medical.

(6) Since the function of a utilization review committee is exclusively medical in nature and purpose, its findings and recommendations should be limited to medical decisions and should not include recommendations with respect to third-party benefits to the patient.

(7) This Association recommends to each component County Medical Society that it point out to the utilization review committees in its county the proper function of such committees and the limits of their responsibilities and obligations.

(8) Each County Medical Society is urged to establish, or cause to be established, a utilization review committee. In event a County Medical

Society does not have sufficient professional personnel available to establish an effective Utilization Review Committee, such County Society is urged to seek the aid of this Association in establishing an area Utilization Review Committee which would function in two or more counties.

4. That the OSMA file an official protest to "Criteria for Determination of Reasonable Charges; Reimbursement for Services of Hospital Interns, Residents and Supervising Physicians" published in the February 8, 1967 issue of *The Federal Register*, and that copies of the protest be forwarded to all state medical associations, the AMA, and to all Ohio Congressmen.

In Regard to Title XIX

It was resolved:

1. That guidelines to determine services that will be reimbursable under Title 19 be submitted to Dr. Theodore Light, the physician member of the Medical Advisory Committee to the Department of Public Welfare, with the request that he review the suggested Guidelines and make suggestions.

a. After this procedure has been followed, the suggested Guidelines be submitted to the Committee on Government Medical Care Programs of the Ohio State Medical Association for study, review and recommendations.

2. That the Department of Welfare should enter

into some form of dialogue with industry and industries which provide goods and services to welfare clients; and that in the future, efforts be made to consider all those who provide services to welfare recipients on the same level and that they be treated equally.

Dependents Medical Care

The Executive Secretary presented a letter from Dr. Charles C. Edwards, Director of the AMA Division of Socio-Economic Activities under date of December 19, 1966, replying to a letter of inquiry by the OSMA on December 12, 1966, with regard to the implementation of Resolution 56 (AMA Annual Session 1966). Such resolution asks for the option of direct billing under the ODMC program and for the payment of the physician's usual and customary fee.

The Council, by official action, stated that the letter is unsatisfactory and asked that its displeasure be expressed to Dr. Edwards. The matter was referred to the Committee on Government Medical Care Programs.

It was announced that the next meeting of The Council will be held at the Holiday Inn, Medina, March 18 and March 19, 1967.

Attest: HART F. PAGE,
Executive Secretary.

KEOGH PLAN AMENDED

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Declaration of Helsinki...

Ethical Guidelines for Clinical Investigation Subscribed to By WMA, AMA, and Other Leading Professional Organizations

THE DECLARATION OF HELSINKI, recommendations guiding doctors in clinical research, was adopted by the World Medical Association in 1964 and endorsed by eight leading professional organizations including the American Medical Association. Following is the text of the declaration, followed by the AMA Ethical Guidelines for Clinical Investigation.

* * *

DECLARATION OF HELSINKI RECOMMENDATIONS GUIDING DOCTORS IN CLINICAL RESEARCH

INTRODUCTION

It is the mission of the doctor to safeguard the health of the people. His knowledge and conscience are dedicated to the fulfillment of this mission.

The Declaration of Geneva of The World Medical Association binds the doctor with the words: "The health of my patient will be my first consideration" and the International Code of Medical Ethics which declares that "Any act or advice which could weaken physical or mental resistance of a human being may be used only in his interest."

Because it is essential that the results of laboratory experiments be applied to human beings to further scientific knowledge and to help suffering humanity, The World Medical Association has prepared the following recommendations as a guide to each doctor in clinical research. It must be stressed that the standards as drafted are only a guide to physicians all over the world. Doctors are not relieved from criminal, civil, and ethical responsibilities under the laws of their own countries.

In the field of clinical research a fundamental distinction must be recognized between clinical research in which the aim is essentially therapeutic for a patient, and the clinical research, the essential object of which is purely scientific and without therapeutic value to the person subjected to the research.

I. BASIC PRINCIPLES

1. Clinical research must conform to the moral and scientific principles that justify medical research

and should be based on laboratory and animal experiments or other scientifically established facts.

2. Clinical research should be conducted only by scientifically qualified persons and under the supervision of a qualified medical man.

3. Clinical research cannot legitimately be carried out unless the importance of the objective is in proportion to the inherent risk to the subject.

4. Every clinical research project should be preceded by careful assessment of inherent risks in comparison to foreseeable benefits to the subject or to others.

5. Special caution should be exercised by the doctor in performing clinical research in which the personality of the subject is liable to be altered by drugs or experimental procedure.

II. CLINICAL RESEARCH COMBINED WITH PROFESSIONAL CARE

1. In the treatment of the sick person, the doctor must be free to use a new therapeutic measure, if in his judgment it offers hope of saving life, re-establishing health, or alleviating suffering.

If at all possible, consistent with patient psychology, the doctor should obtain the patient's freely given consent after the patient has been given a full explanation. In case of legal incapacity, consent should also be procured from the legal guardian; in case of physical incapacity the permission of the legal guardian replaces that of the patient.

2. The doctor can combine clinical research with professional care, the objective being the acquisition of new medical knowledge, only to the extent that clinical research is justified by its therapeutic value for the patient.

III. NONTHERAPEUTIC CLINICAL RESEARCH

1. In the purely scientific application of clinical research carried out on a human being, it is the duty of the doctor to remain the protector of the life and health of that person on whom clinical research is being carried out.

2. The nature, the purpose, and the risk of clinical research must be explained to the subject by the doctor.

3a. Clinical research on a human being cannot be undertaken without his free consent after he has been informed; if he is legally incompetent, the consent of the legal guardian should be procured.

3b. The subject of clinical research should be in such a mental, physical, and legal state as to be able to exercise fully his power of choice.

3c. Consent should, as a rule, be obtained in writing. However, the responsibility for clinical research always remains with the research worker; it never falls on the subject even after consent is obtained.

4a. The investigator must respect the right of each individual to safeguard his personal integrity, especially if the subject is in a dependent relationship to the investigator.

4b. At any time during the course of clinical research the subject or his guardian should be free to withdraw permission for research to be continued.

The investigator or the investigating team should discontinue the research if in his or their judgment, it may, if continued, be harmful to the individual.

We, the undersigned medical organizations, endorse the ethical principles set forth in the Declaration of Helsinki by the World Medical Association concerning human experimentation. These principles supplement the principles of medical ethics to which American physicians already subscribe.

American Federation for Clinical Research
American Society for Clinical Investigation
Central Society for Clinical Research
American College of Physicians
American College of Surgeons
Society for Pediatric Research
American Academy of Pediatrics
American Medical Association

* * *

ETHICAL GUIDELINES FOR CLINICAL INVESTIGATION

*(Adopted by House of Delegates, American
Medical Association, Nov. 30, 1966)*

At the 1966 Annual Convention of its House of Delegates, the American Medical Association endorsed the ethical principles set forth in the 1964 *Declaration of Helsinki* of the World Medical Association concerning human experimentation. These principles conform to and express fundamental concepts already embodied in the *Principles of Medical Ethics* of the American Medical Association.

The following guidelines, enlarging on these fundamental concepts, are intended to aid physi-

cians in fulfilling their ethical responsibilities when they engage in the clinical investigation of new drugs and procedures.

1. A physician may participate in clinical investigation only to the extent that his activities are a part of a systematic program competently designed, under accepted standards of scientific research, to produce data which is scientifically valid and significant.

2. In conducting clinical investigation, the investigator should demonstrate the same concern and caution for the welfare, safety, and comfort of the person involved as is required of a physician who is furnishing medical care to a patient independent of any clinical investigation.

3. In clinical investigation *primarily for treatment* —

A. The physician must recognize that the physician-patient relationship exists and that he is expected to exercise his professional judgment and skill in the best interest of the patient.

B. Voluntary consent must be obtained from the patient, or from his legally authorized representative if the patient lacks the capacity to consent, following: (a) disclosure that the physician intends to use an investigational drug or experimental procedure, (b) a reasonable explanation of the nature of the drug or procedure to be used, risks to be expected, and possible therapeutic benefits, (c) an offer to answer any inquiries concerning the drug or procedure, and (d) a disclosure of alternative drugs or procedures that may be available.

i. In exceptional circumstances and to the extent that disclosure of information concerning the nature of the drug or experimental procedure or risks would be expected to materially affect the health of the patient and would be detrimental to his best interests, such information may be withheld from the patient. In such circumstances such information shall be disclosed to a responsible relative or friend of the patient where possible.

ii. Ordinarily, consent should be in writing, except where the physician deems it necessary to rely upon consent in other than written form because of the physical or emotional state of the patient.

iii. Where emergency treatment is necessary and the patient is incapable of giving consent and no one is available who has authority to act on his behalf, consent is assumed.

4. In clinical investigation *primarily for the accumulation of scientific knowledge* —

A. Adequate safeguards must be provided for the welfare, safety, and comfort of the subject.

B. Consent, in writing, should be obtained from the subject, or from his legally authorized representative if the subject lacks the capacity to consent, following: (a) a disclosure of the fact that an investigational drug or procedure is to be used, (b) a reasonable explanation of the nature of the procedure to be used and risks to be expected, and (c) an offer to answer any inquiries concerning the drug or procedure.

C. Minors or mentally incompetent persons may be used as subjects only if:

i. The nature of the investigation is such that mentally competent adults would not be suitable subjects.

ii. Consent, in writing, is given by a legally authorized representative of the subject under circumstances in which an informed and prudent adult would reasonably be expected to volunteer himself or his child as a subject.

D. No person may be used as a subject against his will.

American College of Physicians Schedules Cincinnati Course

The American College of Physicians will present one of its postgraduate courses in Cincinnati this June.

"Internal Medicine: Current Physiological Concepts in Diagnosis and Treatment" is the name of the course to be presented in cooperation with the University of Cincinnati College of Medicine. Dr. Richard W. Vilter, director of the Department of Medicine in Cincinnati, will be director of the course. There will be the customary registration fee.

The aim of this Postgraduate Course is to provide discussion of various aspects of internal medicine. Particular emphasis will be placed on cell biology, genetics, physiology, and recent advances made through the application of physical and chemical methods. The impact of clinical pharmacology will also be emphasized. In general, the program will consist of morning lectures, and on four days a period of ward rounds in smaller groups. In the afternoon there will be lectures followed by conferences in which discussion will be encouraged. Diagnosis and treatment will be stressed. The subject matter as a whole has been arranged for the busy physician who has a desire to understand the basic mechanism of disease and its management.

All activities are to be held in the Cincinnati General Hospital and adjoining Cincinnati Veterans Administration Hospital, both components of the University of Cincinnati Medical Center. Lectures will be held in the Mont Reid Pavilion of the Cincinnati General Hospital.

THE PHYSICIAN'S BOOKSHELF

Dorland's Illustrated Medical Dictionary, 24th Edition—This latest edition of the well-known medical dictionary has been edited in consultation with numerous authorities in medicine and in the medical publication field. (*W. B. Saunders Company, Philadelphia, Pa.*; \$13.00.)

In view of the mounting complexity of contemporary medical science, the editors have done a remarkable job of bringing a maximum of knowledge within the covers of a single, easily handled volume.

The physician in practice, the student, the writer, as well as other persons in the biomedical sciences will find this volume an indispensable ready reference work, and one of highest authority in the field. Scholars will find that the editors have maintained propriety and used selectivity in bringing this work up-to-date.

"It is our hope," the publishers state, "that a corollary of the conventional use of this Dictionary, to discover the spelling, meaning, and derivation of specific terms, will be assistance in the reverse direction—to aid in the creation of words desired to express new concepts."

Numerous phases of the revision are in keeping with the latest advances in medicine and in the sciences generally. Consistent with the desires of most anatomists to achieve universal adoption of the New Nomina Anatomica, approved by the International Congresses of Anatomists, definitions of the various anatomical structures are based on the N A terms, with appropriate cross references to the more commonly used names.

For physicians who wish to review their basic studies of the technical vocabulary, the editors have included an excellent review entitled "Fundamentals of Medical Etymology." The editors point out that at least 50 per cent of the general English vocabulary is of Greek and Latin derivation, and at least 75 per cent of scientific language is of such origin. For ready reference, several hundred English combining forms that appear most often in the vocabulary are listed with their derivations.

Hundreds of drug names have been added, and many that appeared in previous writings, but no longer in common use, have been dropped. Numerous listings of such entities as chemical elements, muscoli, nervi, weights and measures, etc., are included in the vocabulary. Well chosen illustrations add much to the dictionary's value.

Dr. Herman K. Hellerstein, Cleveland, was one of six physicians honored with an award of merit by the American Heart Association at recent ceremonies in Los Angeles, California.

Keogh Pension Law Revitalized...

Amendment Doubles Tax Deduction Available to Self-Employed Persons, Beginning in 1968; Offers Certain Other Advantages

ON NOVEMBER 13, 1966, the President signed into law H. R. 13103, and with it an amendment to double tax deductions allowable on pension plans established under the Keogh Act, effective for taxable years after 1967. The new amendment also makes certain other advantageous changes in the Act, among them an increase in the amounts that may be contributed toward retirement benefits.

The Keogh Act, officially known as the Self-Employed Individuals Tax Retirement Act, was enacted in 1962 to give self-employed persons the opportunity to defer tax on portions of their incomes set aside for retirement purposes. The law was intended to give self-employed persons at least some of the advantages afforded to corporations in regard to tax deferment on retirement programs.

Unfortunately, many persons found advantages of the Act overbalanced by severe restrictions on amounts allowable toward tax reductions. The recent amendment puts new light on the entire program.

Provisions of the Keogh Act

The Keogh Act is specifically for self-employed persons and their employees. The self-employed person is broadly defined as anyone who owns a business or part of a business which is not incorporated. Specifically, this article is concerned with physicians in private practice, whether as individuals or as partners, and perhaps certain others who would qualify as self-employed persons.

Under the program the self-employed person is both employer and employee. As employer he is permitted to deduct limited amounts of contributions made to pension or profit-sharing plans for himself and qualified employees.

As employee, the self-employed person (like any other employee) is not taxed on such contributions made for his benefit, nor on the income earned on the fund during the accumulation period. He is taxed on benefits received when the time comes for him to receive retirement income.

A partner in a self-employment enterprise is considered self-employed even though his partnership interest is a minor part of the operation, as long as he renders service. A partner who has only an investment interest in the operation, for example, would not be considered self-employed.

The term owner-employee is used in the law for purposes of applying certain rules. An owner-employee is a self-employed person. A partner is not considered an owner-employee unless he owns more than 10 per cent of either the capital interest or the profit interest of the partnership.

For the employer to take advantage of the benefits under this program, in general all employees defined as full-time, with three years or more of service, must be included in the plan and given nonforfeitable rights in the retirement plan.

The self-employed person who has no employees is still eligible under the program. The self-employed person who has already established a retirement plan for his employees, under ordinary circumstances may have the plan amended to include himself as a participant.

Amount of Contributions

The owner-employee may make a contribution to the retirement plan up to 10 per cent of his earned net income, or \$2,500, whichever is less. In general, earned income is considered all income received as professional fees and from similar sources. One authority in this field states: "This is so even though assistants are employed to render part or all of the services, provided the patients or clients, for example, consider the particular professional person responsible for the services rendered."

Contributions for employees eligible under the plan must be made in the same proportion as contributions made by the employer.

Provisions may also be made for participants to make voluntary excess contributions toward the retirement fund. If this is the case, the owner-employee may make similar contributions at the same rate as his employees up to \$2,500 or 10 per cent of his earned income, whichever is less. These voluntary contributions are not tax deductible, but accumulate on a tax-free basis.

Beginning in 1968, most owner-employees may deduct for tax purposes full amounts they contribute for themselves as well as amounts contributed for employees.

For taxable years beginning prior to January 1, 1968, deductions for the owner-employer are limited to one-half the contributions up to a maximum of \$1,250.

Another tax advantage of considerable importance under the Keogh Act is the fact that earnings realized on retirement plan funds accumulate on a tax-free basis.

In general, benefits to the owner-employee under the established program may not begin earlier than at age 59½, nor later than age 70½, with exceptions for permanent disability or death. Restrictions also apply to distribution of benefits to employees, except that an employee may have an established retirement date later than age 70½.

Under limited circumstances the owner-employee may find it to his advantage to integrate his plan with the Social Security program. If he is eligible under this type of plan, his own contributions may not exceed one-third of the total contributions.

Methods of Funding

Retirement plans under the Keogh Act may be funded by various means. In certain situations a trust must be established. Under other circumstances a custodial account with a bank may be used. Still other means are available, depending upon the particular investment being made with the funds. In general, the more speculative the investment the tighter are the administrative requirements. Any plan, trusted or nontrusted, may be established as an "insured plan."

Following is a brief summary of some of the methods available:

Fully Insured Plan—For the professional person, especially one who is only casually acquainted with the investment field, there are many advantages in the fully insured plan. A retirement income policy guarantees a modest profit and a liberal annuity rate. It also guarantees a death benefit for the family in case of death prior to retirement.

Equity Fund—The plan may be funded through contributions to a trust, with a bank trustee or an individual trustee named. The type of investment is significant from the standpoint of who may serve as trustee. In lieu of a trust, a custodial account with a bank may be used.

Combination Plan—This plan provides for part of the fund to be invested in life policies and the balance invested through the trust department of a bank.

Annuity Plan—An annuity policy is similar to a retirement income policy but without a death benefit.

Government Bonds Plan—The Keogh Act provides for a form of retirement plan involving direct investment in special government bonds designed for this purpose.

Planning for the Program

Any retirement program is a long-range project, and the self-employed person owes it to himself and to his employees to consider the pros and cons from every angle. Simple prototype plans, already ap-

proved by the Internal Revenue Service, are available. Business advisors, investment bankers, tax consultants, attorneys, and insurance agents are among the persons who can be of help.

The Ohio State Medical Association's Committee on Insurance recently studied the advisability of a Keogh-type plan program for OSMA members. In a report approved by The Council, the committee expressed the opinion that the advantages of a single statewide plan are not evident at this time.

Ohio's Call by Selective Service Is for 100 Medical Doctors

A letter addressed to chairmen of County Military Advisory Committees in this state announced that Ohio's portion of the recent call from Selective Service would be for 100 "Medical Doctors." The letter was sent by Drew L. Davies, M. D., chairman of the Ohio Military Advisory Committee.

Quoting Colonel William P. Richardson, chief of the Manpower Division, Ohio Selective Service, the letter stated: "The Department of Defense announced there would be 2,118 Medical Doctors called; 1,461 to be assigned to the Army; and 657 to the Navy."

The quotation from Colonel Richardson further stated: "The persons granted commissions will not be called sooner than July 1, 1967. *** Each physician will be given at least one month's prior notice before his Order to Report for Induction becomes effective. In other words, if we (Ohio Selective Service) issue any Orders to Report for Induction for July 1, 1967, they must be mailed by the Local Board by June 1, 1967."

Dr. Davies concluded his letter to local chairmen as follows: "I am forwarding this information to you so that you will be prepared for the requests for recommendations regarding doctors to be selected. It appears that there will not be enough interns to fulfill this call for 100 Medical Doctors."

The Cleveland Clinic Foundation Offers Educational Courses

The Cleveland Clinic Educational Foundation is offering two short courses in April of particular interest to physicians—one in gastroenterology and one in endocrinology.

"Diagnostic Procedures in Gastroenterology" is the title of a course scheduled April 5 and 6.

A course entitled "Diabetes Mellitus: The Old and the New" will be presented April 26 and 27.

Details on these and other courses offered by the clinic may be obtained from Walter J. Zeiter, M. D., Director of Education, The Cleveland Clinic Educational Foundation, 2020 East 93rd Street, Cleveland, Ohio 44106.

OMPAC Membership Escalating . . .

Excellent Returns Shown for Early Months; More than 500 New Members Paid Dues; Physicians Urged to Join Campaign

As this issue of *The Journal* went to press, membership of the Ohio Medical Political Action Committee stood at 2,259. In comparison, the 1966 OMPAC membership for the entire year was 2,989. About 500 of those who have joined for 1967 are new members.

Hoping to exceed the 1966 membership by a sizeable amount, officers of OMPAC are making an urgent request to physicians who were members in 1966 to immediately reaffiliate by paying 1967 OMPAC dues to the Secretary-Treasurer of the respective County Medical Society.

Following is a tabulation of the number of 1967 OMPAC members to date by Counties and by Councilor Districts, compared to 1966 figures:

OMPAC Membership Dec. 31, 1966		OMPAC Membership to date, 1967		OMPAC Membership Dec. 31, 1966		OMPAC Membership to date, 1967		OMPAC Membership Dec. 31, 1966		OMPAC Membership to date, 1967													
First District				Lucas -----		61 -----		2 -----		Licking -----		14 -----		1 -----									
Adams -----				1 -----		3 -----		Ottawa -----		8 -----		9 -----		Morgan -----		0 -----							
Brown -----				7 -----		49 -----		Paulding -----		1 -----		2 -----		Muskingum -----		26 -----		13 -----					
Butler -----				78 -----		49 -----		Putnam -----		1 -----		0 -----		Noble -----		1 -----		2 -----					
Clermont -----				4 -----		8 -----		Sandusky -----		14 -----		14 -----		Perry -----		3 -----		2 -----					
Clinton -----				5 -----		8 -----		Williams -----		0 -----		2 -----		Washington -----		0 -----		2 -----					
Hamilton -----				427 -----		336 -----		Wood -----		4 -----		3 -----											
Highland -----				0 -----												97 -----		49 -----					
Warren -----				11 -----		1 -----				103 -----		36 -----											
				533 -----		397 -----																	
Second District																							
Champaign -----				8 -----		8 -----		Fifth District															
Clark -----				54 -----		45 -----		Ashtabula -----		17 -----		9 -----		Ninth District									
Darke -----				7 -----		7 -----		Cuyahoga -----		415 -----		304 -----		Gallia -----		4 -----		5 -----					
Greene -----				19 -----		15 -----		Geauga -----		10 -----		8 -----		Hocking -----		1 -----							
Miami -----				37 -----		38 -----		Lake -----		57 -----		49 -----		Jackson -----		0 -----							
Montgomery -----				224 -----		196 -----				499 -----		370 -----		Lawrence -----		15 -----		11 -----					
Preble -----				0 -----				Sixth District						Meigs -----		0 -----							
Shelby -----				15 -----		18 -----		Columbiana -----		5 -----		5 -----		Pike -----		0 -----							
				364 -----		327 -----		Mahoning -----		91 -----		82 -----		Scioto -----		33 -----		28 -----					
								Portage -----		29 -----		25 -----		Vinton -----		0 -----							
								Stark -----		181 -----		133 -----						53 -----		44 -----			
								Summit -----		88 -----		49 -----											
								Trumbull -----		58 -----													
										452 -----		294 -----											
Third District								Seventh District															
Allen -----				70 -----		73 -----		Belmont -----		19 -----		20 -----		Tenth District									
Auglaize -----				2 -----		5 -----		Carroll -----		6 -----		6 -----		Delaware -----		7 -----		12 -----					
Crawford -----				35 -----		29 -----		Coshocton -----		1 -----		2 -----		Fayette -----		12 -----		14 -----					
Hancock -----				3 -----		4 -----		Harrison -----		6 -----		5 -----		Franklin -----		418 -----		351 -----					
Hardin -----				0 -----				Jefferson -----		4 -----				Knox -----		25 -----		20 -----					
Logan -----				0 -----				Monroe -----		0 -----				Madison -----		2 -----		4 -----					
Marion -----				14 -----		7 -----		Tuscarawas -----		26 -----		4 -----		Morrow -----		2 -----		5 -----					
Mercer -----				2 -----		1 -----								Pickaway -----		6 -----		10 -----					
Seneca -----				23 -----		17 -----								Ross -----		21 -----		21 -----					
Van Wert -----				10 -----		10 -----								Union -----		2 -----		2 -----					
Wyandot -----				3 -----		2 -----																	
				162 -----		148 -----				62 -----		37 -----											
Fourth District								Eighth District															
Defiance -----				4 -----		4 -----		Athens -----		13 -----				Eleventh District									
Fulton -----				3 -----				Fairfield -----		36 -----		29 -----		Ashland -----		6 -----		11 -----					
Henry -----				7 -----				Guernsey -----		4 -----				Erie -----		0 -----		4 -----					
														Holmes -----		7 -----		5 -----					
														Huron -----		14 -----		12 -----					
														Lorain -----		58 -----		47 -----					
														Medina -----		18 -----		12 -----					
														Richland -----		37 -----							
														Wayne -----		29 -----		27 -----					
																				169 -----		118 -----	

Office of the President

L. C. MEREDITH, M.D.
205 Elyria Block, Elyria, Ohio 44035
Telephone: 322-7424

Ohio State
Medical
Association

April 1, 1967

Dear Member:

The past eleven months of my Presidency of your Association have been eventful ones, filled with activity of all types; scientific, socio-economic and social. I am writing to you to urge that you attend the 1967 O.S.M. A. Annual Meeting, May 15-19 in Columbus. During these five days all the phases of medical organization activity will be covered in postgraduate scientific sessions, business sessions of the House of Delegates and at the primary social function The Gaslight Party.

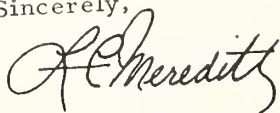
On the succeeding pages you will be able to see, briefly, the what, where and when of these activities. Your official program, including all the details about the Annual Meeting will be mailed directly to you on April 15. Take the time to peruse it. The Committee on Scientific Work has planned an excellent, quality meeting. It would be worth your while to attend just to spend time at the 35 Scientific Exhibits. Closed circuit color television direct from Ohio State University Hospital is an innovation.

Become interested in your Association. Take pride in your membership. Demonstrate that interest and pride by your attendance at the Annual Meeting.

You are obligated to continue your educational experience in order to better serve your patients. Our Annual Meeting is designed to fulfill that need.

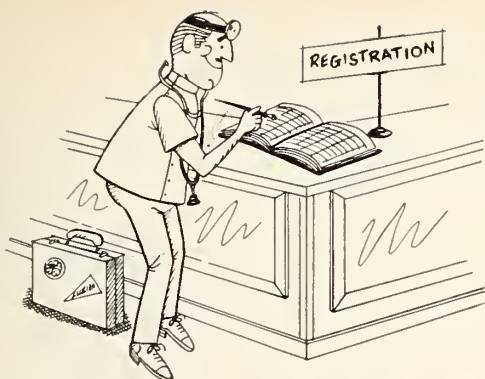
I hope that I will see you in May.

Sincerely,



L. C. Meredith, M. D.
President

LCM:gd



Make Your

HOTEL RESERVATIONS

FOR THE

1967 OSMA ANNUAL MEETING COLUMBUS MAY 15-19

Leading Downtown Columbus Hotels and Prevailing Rates

SHERATON-COLUMBUS MOTOR HOTEL 50 North Third Street

Singles	\$11.50 - \$15.50
Twins	\$15.50 - \$19.50

BEASLEY-DESHLER HOTEL West Broad and North High Streets

Singles	\$ 9.50 - \$14.50
Doubles	\$15.50 - \$20.00
Twins	\$16.50 - \$20.00

NEIL HOUSE 41 South High Street

Singles	\$ 8.50 - \$15.00
Doubles	\$12.00 - \$18.00
Twins	\$12.00 - \$20.00

HOTEL SOUTHERN South High and East Main Streets

Singles	\$ 8.00 - \$ 9.50
Doubles	\$11.00 - \$12.50
Twins	\$12.00 - \$15.00

CHRISTOPHER INN 300 East Broad Street

Singles	\$12.50
Doubles	\$16.00
Twins	\$18.00

PICK-FORT HAYES HOTEL 31 West Spring Street

Singles	\$ 8.00 - \$13.50
Doubles	\$13.50 - \$14.50
Twins	\$13.50 - \$18.00

*All rates subject
to change*

If you plan to share a room, please
indicate name of roommate.

HOTEL RESERVATION BLANK

(Mail to Hotel of Choice)

(NAME OF HOTEL)

(ADDRESS) Columbus, Ohio

Please reserve the following accommodations during the period of the Ohio State Medical Association Annual Meeting, May 15 - 19 (or for period indicated)

- ☐ Single Room
☐ Double Room
☐ Twin Room

Other accommodations _____

Price range _____

Arriving May _____ at _____ A.M. _____ P.M.

PLEASE VERIFY MY RESERVATION

Name _____

Address _____

5¢



BEER IS BACK

DURING THE OSMA ANNUAL MEETING
AT

The Gaslight Party

THURSDAY, MAY 18
7:00 P.M. 'til . . . ?

THE NEIL HOUSE
41 SOUTH HIGH STREET
COLUMBUS



SEE *the fun that can be had by all*

FOOD!!!

ol' fashun pickel barrel
giant cheese wheels
stuff to make sandwiches
cold sauerkraut
nuts, chips, and all that

and **5¢**

BEER IS BACK



DANCING!!!

You Must Bring
Your Personal
Flapper Girl . . .



ENTERTAINMENT!!!

THE GASLIGHT ROAD SHOW . . .
(direct from Chicago's
Gaslight Club)

THE KEYSTONE BROTHERS
(piano and banjo)

THE AL MYERS' QUARTET
(Dixieland)

come dressed like the
Roaring 20's if you wish . . .

SOMETHING
will always
be
HAPPENING!!



FIND THE GIRL WITH THE GOLDEN GARTER . . .
WIN A BOTTLE OF CHAMPAGNE !



Don't Miss It . . .
Mark Your Calendar Now
Write for Tickets . . .

\$8.00 per person

See You There

Complete and Forward to:

GASLIGHT PARTY
MAY 18

The Ohio State Medical Association
17 South High Street, Suite 500
Columbus, Ohio 43215

OMPAC LUNCHEON
MAY 16

Enclosed is \$ to pay for:

. Tickets to Gaslight Party (\$8.00 per person)

. Tickets to OMPAC Luncheon (\$5.00 per person)

Please make checks payable to:
THE OHIO STATE MEDICAL
ASSOCIATION

Name:
Street Address:
City and State:

HELP KEEP THE STRENGTH IN THE PROFESSION'S

STRONG RIGHT ARM

Attend . . .

THE OHIO MEDICAL POLITICAL ACTION COMMITTEE LUNCHEON

TUESDAY, MAY 16
Celestial Ballroom
Sheraton-Columbus Hotel



Congressman
Ashbrook

The Honorable JOHN M. ASHBROOK

CONGRESSMAN
SEVENTEENTH OHIO DISTRICT

will speak on . . .

The Role of the Physician in Politics

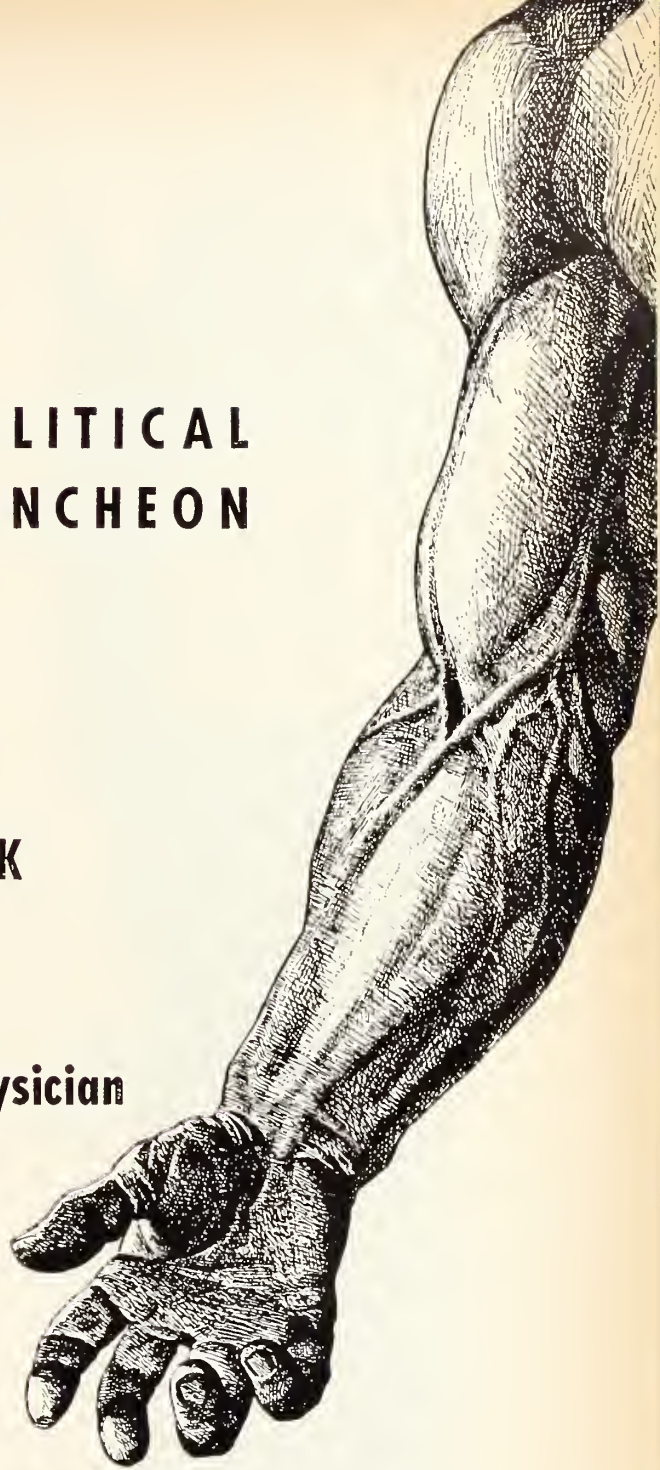
11:45 A.M. Cash Bar

12:15 P.M. Luncheon

1:00 P.M. "OMPAC Hits the Bull's Eye"—
A Progress Report

1:15 P.M. The Role of the Physician in Politics
Hon. John M. Ashbrook

Congressman Ashbrook will speak about why it is important for *all* physicians to be active in politics and will explain the role active physicians played in a successful campaign.



TICKETS . . .

\$5.00 per person

Complete the form on the facing page and forward to:

The Ohio State Medical
Association

Summary of

Daily Schedule

MONDAY, MAY 15

6:30 P. M.

OSMA House of Delegates Registration

Terrestrial Promenade, Second Floor
(Sheraton-Columbus)

8:00 P. M.

OSMA House of Delegates First Business Session

Saturn Room, Second Floor
(Sheraton-Columbus)

TUESDAY, MAY 16

8:30 A. M.

Breakfast Meeting Ohio Committee on Trauma, A.C.S.

Grant Room, Third Floor
(Sheraton-Columbus)

9:00 A. M.

Registration for Exhibitors Opens

West Entrance Lobby, Exhibit Hall, Ground Floor
(Veterans Memorial Building)

9:00 A. M.

OSMA General Registration Opens

Terrestrial Promenade, Second Floor
(Sheraton-Columbus)

9:00 A. M.

Resolutions Committee No. 1

Auditorium, Third Floor
(Sheraton-Columbus)

Resolutions Committee No. 2

China and Malay Rooms, Second Floor
(Sheraton-Columbus)

Resolutions Committee No. 3

Taft Room, Third Floor
(Sheraton-Columbus)

9:00 A. M.

Committee on President's Address

North Room, Second Floor
(Sheraton-Columbus)

Committee on Nominations

Garfield and Hayes Rooms, Third Floor
(Sheraton-Columbus)



10:00 A. M.

General Session

Presented by The Ohio Committee on Trauma,
American College of Surgeons, and OSMA Section
on Plastic Surgery

"Auto Injuries"

Venus and Mars Rooms, Second Floor
(Sheraton-Columbus)

11:45 A. M.

OMPAC Luncheon

Saturn Room, Celestial Ballroom, Second Floor
(Sheraton-Columbus)

1:30 P. M.

Business Meeting

OSMA Section on Plastic Surgery

Taft Room, Third Floor
(Sheraton-Columbus)

2:00 P. M.

Ohio Committee on Trauma, American College of Surgeons Executive Committee Meeting

Grant Room, Third Floor
(Sheraton-Columbus)

2:30 P. M.

OSMA House of Delegates Inaugural Session

Mars and Venus Rooms, Second Floor
(Sheraton-Columbus)

4:30 P. M.

Reception for Exhibitors Hosted By OSMA Officers and House of Delegates

Terrestrial Promenade, Second Floor
(Sheraton-Columbus)

5:30 P. M.

Ohio Society of Internal Medicine Board of Trustees Meeting

Garfield and Hayes Rooms, Third Floor
(Sheraton-Columbus)

WEDNESDAY, MAY 17

9:00 A. M.

Scientific, Health-Education and Technical Exhibits Open

West Entrance Lobby, Exhibit Hall, Ground Floor
(Veterans Memorial Building)

OSMA Registration Opens

West Entrance Lobby, Exhibit Hall, Ground Floor
(Veterans Memorial Building)

9:00 A. M.

General Session

Closed Circuit Color TV Program from University Hospital
sponsored by OSU College of Medicine

"Surgery for Removal of the Gall Bladder"

Robert M. Zollinger, M.D.
Assembly Hall, Veterans Wing, First Floor
(Veterans Memorial Building)

10:00 A. M.

Intermission for Tour of Exhibits

10:00 A. M.

Ohio Ophthalmological Society Annual Meeting

Athletic Club of Columbus
(136 East Broad St.)

10:30 A. M.

General Session

Sponsored by the Ohio State Heart Association
Assembly Hall, Veterans Wing, First Floor
(Veterans Memorial Building)

11:00 A. M.

Ohio Health Commissioners' Meeting With Director

Room 201, Second Floor
(Veterans Memorial Building)

12:00 NOON

Luncheon, American Medical Women's Association Branch 12

Memorial Room, First Floor
(Veterans Memorial Building)

12:00 NOON

Ohio Ophthalmological Society Luncheon

Athletic Club of Columbus
(136 East Broad St.)

NOTE: Chartered Bus Transportation Back to
Veterans Memorial Building at 1:35 P. M.

1:30 P. M.

General Session

"Educating Patients About Sexual Relationships"

Main Auditorium, First Floor
(Veterans Memorial Building)

2:00 P. M.

Section on Ophthalmology and Ohio Ophthalmological Society

Room V-M 22, Veterans Wing Mezzanine
(Veterans Memorial Building)

3:00 P. M.

Intermission for Tour of Exhibits

3:30 P. M.

**Section on General Practice of
Medicine, Section on Physical
Medicine and Rehabilitation, and
Ohio Society of Physical Medicine
and Rehabilitation**

South Terrace, Ground Floor
(Veterans Memorial Building)

3:30 P. M.

**Section for Hospital Directors
of Medical Education**

Room G-3, Ground Floor
(Veterans Memorial Building)

3:30 P. M.

Internal Medicine

Rooms 206-207, Second Floor
(Veterans Memorial Building)

Psychiatry

Workshop on Group Therapy

Assembly Hall, Veterans Wing, First Floor
(Veterans Memorial Building)

3:30 P. M.

Ohio Health Commissioners' Institute

FIRST SESSION

Room 201, Second Floor
(Veterans Memorial Building)

6:30 P. M.

**Ohio Society of Internal Medicine;
OSMA Section on Internal Medicine
Reception and Dinner**

Athletic Club of Columbus, Main Dining Room
(136 East Broad Street)

5:00 P. M.

**Ohio Psychiatric Association
Social Hour, Dinner, and Speaker**

Venus Room, Second Floor
(Sheraton-Columbus)

6:00 P. M.

**Physical Medicine Social Hour,
Dinner, and Speaker**

(Place to be Announced)

6:30 P. M.

**Section for Hospital Directors of
Medical Education**

Stouffer's University Inn
3025 Olentangy River Rd.
Social Hour and Dinner

7:00 P. M.

**Ohio Health Commissioners'
Banquet**

(Parlor 8, The Neil House)

THURSDAY, MAY 18

9:00 A. M.

**Scientific, Health-Education and
Technical Exhibits Open**

West Entrance Lobby, Exhibit Hall, Ground Floor
(Veterans Memorial Building)

OSMA Registration Opens

West Entrance Lobby, Exhibit Hall, Ground Floor
(Veterans Memorial Building)

9:00 A. M.

General Session

Closed Circuit Color TV Program from University Hospital
sponsored by OSU College of Medicine

"Office Proctology" and "Lacerations"

Assembly Hall, Veterans Wing, First Floor
(Veterans Memorial Building)

9:00 A. M.

Ohio Psychiatric Association

South Terrace, Ground Floor
(Veterans Memorial Building)

9:00 A. M.

**Ohio Health Commissioners' Institute
SECOND SESSION**

Room 201, Second Floor
(Veterans Memorial Building)

10:00 A. M.

Intermission for Tour of Exhibits

10:30 A. M.

General Session

Sponsored by Ohio Division, Inc.
American Cancer Society
Assembly Hall, Veterans Wing, First Floor
(Veterans Memorial Building)

11:30 A. M.

**Ohio Psychiatric Association
Luncheon and Meeting**

Venus Room, Second Floor
(Sheraton-Columbus)

1:30 P. M.

General Session

**"Drug Regulations and Compulsory
Generic Prescribing"**

Main Auditorium, First Floor
(Veterans Memorial Building)

1:30 P. M.

**Ohio Health Commissioners' Institute
THIRD SESSION**

Room 201, Second Floor
(Veterans Memorial Building)

2:30 P. M.

Intermission for Tour of Exhibits

3:00 P. M.

Occupational Medicine

Rooms 206-207, Second Floor
(Veterans Memorial Building)

3:00 P. M.

Psychiatry

Assembly Hall, Veterans Wing, First Floor
(Veterans Memorial Building)

3:00 P. M.

Pediatrics, Obstetrics, and Gynecology

South Terrace, Ground Floor
(Veterans Memorial Building)

Radiology

Room V-M 22, Veterans Wing, Mezzanine
(Veterans Memorial Building)

7:00 P. M.

THE GASLIGHT PARTY

The Neil House
41 South High Street
(Presidential and Governors Ballrooms and Foyer)

FRIDAY, MAY 19

9:00 A. M.

Scientific, Health-Education and Technical Exhibits Open

West Entrance Lobby, Exhibit Hall, Ground Floor
(Veterans Memorial Building)

OSMA Registration Opens

West Entrance Lobby, Exhibit Hall, Ground Floor
(Veterans Memorial Building)

OSMA House of Delegates

FINAL SESSION

Saturn and Jupiter Rooms, Second Floor
(Sheraton-Columbus)

9:00 A. M.

General Session

Closed Circuit Color TV Program from University Hospital
Sponsored by OSU College of Medicine
Assembly Hall, Veterans Wing, First Floor
(Veterans Memorial Building)

"Physical Treatment in the Home"
"Bedside Pulmonary Function Testing"
"Dermatology"

9:00 A. M.

Pediatrics

Auditorium, Third Floor
(Sheraton-Columbus)

9:00 A. M.

Laboratory Medicine

South Terrace, Ground Floor
(Veterans Memorial Building)

9:00 A. M.

Ohio Health Commissioners' Institute

FOURTH SESSION

Room 201, Second Floor
(Veterans Memorial Building)

10:30 A. M.

Intermission for Tour of Exhibits

11:00 A. M.

General Session

"Computerized and Automated Medicine"

Assembly Hall, Veterans Wing, First Floor
(Veterans Memorial Building)

1:30 P. M.

General Session

Featuring Milford O. Rouse, M. D., President-Elect,
American Medical Association
Main Auditorium, First Floor
(Veterans Memorial Building)

2:30 P. M.

Intermission for Tour of Exhibits

3:00 P. M.

Anesthesiology

Rooms 206-207, Second Floor
(Veterans Memorial Building)

Chest Physicians

Room V-M 22, Veterans Wing, Mezzanine
(Veterans Memorial Building)

Neurosurgery

Room 205, Second Floor
(Veterans Memorial Building)

Pathology

Assembly Hall, Veterans Wing, First Floor
(Veterans Memorial Building)

3:00 P. M.

All Exhibits Close

6:00 P. M.

Annual Meeting Officially Closes

7:00 P. M.

Ohio Society of Medical Technologists and the Ohio Society of Pathologists Cocktail Hour Followed by Dinner

8:00 P. M.

Christopher Inn
300 E. Broad St.

7:00 P. M.

Ohio Neurosurgical Society and OSMA Section on Neurological Surgery

Social hour followed by dinner at Top of the Center,
City National Bank Building, 100 East Broad St.

Ohio ENT Program . . .

Ohio ENT Society and OSMA Section on ENT to Hold Joint Session in Downtown Columbus, April 14 - 15

THE Ohio Ear, Nose, and Throat Society, in cooperation with the OSMA Section on Ear, Nose, and Throat will present its 1967 Annual Meeting in Columbus, April 14 and 15.

The two groups will hold a reception for members and wives at the Sheraton-Columbus Motor Hotel on Friday, April 14, beginning at 7:00 P. M. Dinner arrangements will be up to the individuals attending.

Scientific sessions are to be held at the School of Dentistry Auditorium, Ohio State University, beginning at 9:00 A. M. on April 15. Registration will open at 8:15 A. M. A complete program is listed below. All OSMA members are invited to attend. Those planning to do so should complete the form at the bottom of this page and forward to: R. L. Ruggles, M. D., 10515 Carnegie Ave., Cleveland, Ohio 44106.

Program

Friday, April 14

7:00 P. M.

**Reception for Members, Guests,
and Wives**

Sheraton-Columbus Motor Hotel

Saturday, April 15

Auditorium

School of Dentistry

Ohio State University

8:15 A. M.

Registration

Saturday (Contd.)

9:00 A. M.

Welcome

Stephen Hogg, M. D., Cincinnati, President
Ohio Society of Ear, Nose, and Throat

9:10 A. M.

"Glomus Tumors"

John Conley, M. D.
New York City

9:50 A. M.

Open Discussion

10:00 A. M.

"Dizziness, Diagnosis, and Therapy"

PART I

Fred R. Guilford, M. D.
Houston, Texas

10:40 A. M.

Open Discussion

10:50 A. M.

**"Trauma of the Larynx and Upper
Respiratory Tree"**

Donald A. Shumrick, M. D.
Cincinnati, Ohio

11:30 A. M.

Open Discussion

Clip and Forward

R. L. Ruggles, M. D.
10515 Carnegie Ave.
Cleveland, Ohio 44106

Dear Dr. Ruggles:

I plan to attend the Joint Meeting of the Ohio State Medical Association Section on Ear, Nose, and Throat and the Ohio Society of Ear, Nose, and Throat on April 14 - 15.

I will — I will not — be staying at the Sheraton-Columbus.

I will — I will not — attend the Cocktail Party on Friday, April 14.

I will — I will not — be staying for lunch at the Ohio Student Union.

Name:.....

Address:.....

City:.....

Saturday (Contd.)

12:00 NOON

Luncheon

Ohio Student Union
The Ohio State University

1:30 P. M.

Dentistry Auditorium
"Dizziness, Diagnosis, and Therapy"

Part II

Fred R. Guilford, M. D.
Houston, Texas

2:10 P. M.

Open Discussion

2:20 P. M.

"Glossectomy"
John Conley, M. D.
New York City

3:00 P. M.

Open Discussion

3:10 P. M.

"Esophageal and Pyloric Stenosis
Following Ingestion of Caustic Agents
Jack Kerth, M. D.
Cleveland, Ohio

3:30 P. M.

Open Discussion

3:40 P. M.

Business Meeting

4:00 P. M.

Adjournment

Two Key Appointments Announced At Ohio State University

Two major appointments in the Ohio State University College of Medicine received recent approval of the university's Board of Trustees.

Dr. Stuart S. Roberts, acting head of surgery at the University of Illinois, was named the first holder of the Robert M. Zollinger Chair of Surgery at Ohio State, effective March 1.

Dr. R. Dean Coddington, 42, of the University of Florida, was appointed director of the Division of Child Psychiatry in the College of Medicine and professor in the Department of Psychiatry and Pediatrics. He will join the faculty May 1.

Dr. Roberts will have academic rank of professor. The Zollinger Chair of Surgery was established in honor of Dr. Robert M. Zollinger, chairman of the Department of Surgery and a Regents' Professor at Ohio State.

Training Program Held in Columbus For Rehabilitation Counselors

Faculty members of Northwestern University Medical School, Chicago, and Ohio State University College of Medicine met in Columbus the week of January 30 - February 3 to conduct in-service training for 39 counselors of the Ohio Bureau of Vocational Rehabilitation.

Recent growth of Ohio's vocational rehabilitation services for the handicapped and an increase in the number of staff members resulted in moving the training program to Ohio. Previously Ohio BVR counselors went for their in-service training sessions to Northwestern, one of three national centers for training in prosthetics and orthotics.

The program entitled "Rehabilitation of the Amputee," was conducted by 16 persons, each a specialist in some phase of rehabilitation work.



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MEMBER: American Hospital Association — National Association of Private Psychiatric Hospitals — Ohio Hospital Association

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3. Cites synergism between androgen and thyroid.
4. No side effects in patients treated.
5. Alleviation of fatigue noted.
6. Case histories on 4 patients.
7. Although psychotherapy still needed, role of chemotherapy cannot be disputed.

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Methyl Testosterone	5.0 mg.
Thyroid Ext. (1/2 gr.)	30 mg.
Glutamic Acid	50 mg.
Thiamine HCL	10 mg.

Dose: 1 tablet 3 times daily.

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Bottles of 100, 500, 1000.

Each orange tablet contains:

Methyl Testosterone	12.5 mg.
Thyroid Ext. (1 gr.)	64 mg.
Glutamic Acid	50 mg.
Thiamine HCL	10 mg.

Dose: 1 or 2 tablets daily.

Available:

Bottles of 60, 500.

Each white tablet contains:

Methyl Testosterone	2.5 mg.
Thyroid Ext. (1/4 gr.)	15 mg.
Ascorbic Acid (Vit. C)	250 mg.
Thiamine HCL	25 mg.
Glutamic Acid	100 mg.
Pyridoxine HCL	5 mg.
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Ad Astra

Clarence D. Selby, M.D., Port Huron, Mich.; Western Reserve University School of Medicine, 1902; outstanding authority in the field of occupational and preventive medicine, and a Past President of the Ohio State Medical Association, died at the age of 88 on February 26.

A former resident of Toledo, Dr. Selby was an early worker in medical organization affairs, and was President of the Ohio State Medical Association in 1925 and 1926. A former practicing physician and

surgeon in Toledo, Dr. Selby became medical consultant to General Motors during the 1930's and moved to Detroit. When he retired from that position in 1949 at the age of 71, a GM official said of him:

"Dr. Selby's contribution to advances in the field of industrial medicine has been tremendous. I know of no one who has done more to promote a better understanding of the importance to the whole economy of



C. D. Selby, M.D.
(Photo about 1949)

maintaining the highest possible health standards among industrial workers and executives. The constantly improving health record of General Motors' employees is in itself a tribute to the pioneering efforts and the leadership he has shown in this field."

Dr. Selby was born in Des Moines, Iowa, and after receiving his medical degree from Western Reserve took up the practice of medicine in Toledo. He was also health commissioner for Toledo. Although living in Michigan, Dr. Selby maintained his membership in the Ohio State Medical Association. Other professional affiliations included membership in the American Medical Association, the American Academy of Occupational Medicine, Industrial Medical Association, and the American College of Preventive Medicine; he was also a diplomate of the American Board of Preventive Medicine.

Harold Harris Biggs, M.D., Wadsworth; Western Reserve University School of Medicine, 1916; aged 76; died February 27; former member of the Ohio State Medical Association. A practitioner of many years standing in Wadsworth, Dr. Biggs was formerly secretary of the Medina County Medical Society. Before 1921, he was associated with the medical department of the Goodrich Rubber Company in Akron.

Harley Owen Bratton, M.D., Columbus; Ohio Medical University, Columbus, 1907; aged 83; died February 10; member of the Ohio State Medical Association, the American Medical Association, and the American Urological Association. A practitioner in the Columbus area for some 54 years, Dr. Bratton specialized in urology. He is survived by his widow and a daughter.

Jay Walter Calhoon, M.D., Fort Lauderdale, Florida; Ohio State University College of Medicine, 1921; aged 70; died February 7; former member of the Ohio State Medical Association; member of the American Medical Association, and the American Academy of General Practice. A practitioner of many years standing in Uhrichsville, Dr. Calhoon moved to Florida in 1963 and continued his practice there. While in Ohio, he was a member of the OSMA Committee on Legislation. He was a member of the American Legion, the Methodist Church, and several Masonic bodies. Surviving are his widow, a brother, and five sisters.

Walter Lewis Evans, M.D., Worthington; Western Reserve University School of Medicine, 1933; aged 58; died February 17; member of the Ohio State Medical Association, the American Medical Association, and the American Thoracic Society. Beginning in 1960, Dr. Evans was chief of the Division of Tuberculosis of the Ohio Department of Health and a member of the faculty at Ohio State University College of Medicine. In recent months he was acting superintendent of the Southeastern Ohio Tuberculosis Hospital in Nelsonville. Surviving are his widow, two daughters, and a son.

Lawton C. Gerlinger, M.D., Dayton; Ohio State University College of Medicine, 1933; aged 60; died February 7; member of the Ohio State Medical Association and the American Medical Association. Dr. Gerlinger was in private practice for many years in Fostoria, and two years ago accepted an appointment on the staff of the Veterans Administration Hospital in Dayton. He was a member of the Masonic Lodge and the Lutheran Church. Two physicians are among survivors — his son, Dr. Lawton C. Gerlinger, Jr., of Detroit, and a brother, Dr. Theodore Gerlinger. Other survivors are his widow, a daughter, his mother, a step-son and a step-daughter; also a sister.

Walter H. Hamilton, M.D., Columbus; Ohio State University College of Medicine, 1922; aged 68; died February 22; member of the Ohio State

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Medical Association, the American Medical Association, American Proctologic Society; Fellow of the American College of Surgeons. A practicing physician of long standing in Columbus, Dr. Hamilton's practice was in the field of proctology and surgery. Four sons are professional men, Drs. Edwin B., Charles H., Walter W., and James. Also surviving are his widow, a daughter, and his mother.

Laurel B. Hurless, M.D., Dayton; Northwestern University Medical School, 1928; aged 69; died February 6; member of the Ohio State Medical Association and the American Medical Association. The professional career of Dr. Hurless in the Dayton area extended over a period of 40 years. He is survived by his widow, a son, and a sister.

Bert E. Leatherman, M.D., Toledo; Starling Medical College, Columbus, 1906; aged 88; died January 30; former member of the Ohio State Medical Association. Dr. Leatherman was retired after a practice of many years standing in Toledo where he specialized in the EENT field. He was a member of the Presbyterian Church and several Masonic bodies. Surviving are his widow, a daughter, and two sisters.

John Edward Monnig, M.D., Akron; University of Cincinnati College of Medicine, 1912; aged 83; died February 26; member of the Ohio State Medical Association and the American Medical Association. Dr. Monnig's practice in Akron extended over approximately 52 years. Among survivors are his widow, two daughters, and a brother.

Frank L. Rattermann, M.D., Cincinnati; Medical College of Ohio, Cincinnati, 1896; aged 92; died January 23; member of the Ohio State Medical Association and the American Medical Association. Dr. Rattermann practiced medicine for 60 years before his retirement in 1956. A member of the Catholic Church, he is survived by his widow, a brother, and a grandchild.

Jacob Marcus Rieger, M.D., Cleveland; University of Kansas School of Medicine, 1929; aged 66; died February 1; member of the Ohio State Medical Association. Dr. Rieger was a general practitioner in Cleveland, and began his practice there in 1929. Among survivors are his widow, a son, his son-in-law and daughter, Dr. and Mrs. Marvin Sobel; also two brothers and a sister.

Ralph Robinson, M.D., Cleveland; Cornell University Medical College, 1906; aged 86; died February 22; former member of the Ohio State Medical Association and the American Medical Association. Dr. Robinson moved to Cleveland in 1920 after formerly serving as health officer in Lackawanna,

New York, and serving in the Medical Corps during World War I. He retired only last year. Among affiliations, he was a member of the Presbyterian Church. Dr. Dean G. Robinson, of Van Alstyne, Texas, is a son. Other survivors are his widow, three daughters, another son, and a sister.

Edwin Shields Shane, M.D., Circleville; Ohio State University College of Medicine, 1927; aged 71; died February 7; member of the Ohio State Medical Association and the American Medical Association. A practitioner in the Circleville area for virtually all of his professional career, Dr. Shane was a past president of the Pickaway County Medical Society, a former delegate to the OSMA, and a member of the Board of Governors of Berger Hospital. He was a veteran of both World Wars, having served with the Army in WW I and with the Navy in WW II. Among affiliations, he was a member of the Presbyterian Church and the Elks Lodge. Two sisters survive.

Jacob E. Tuckerman, M.D., Cleveland; Western Reserve University School of Medicine, 1902; aged 90; died February 27; member of the Ohio State Medical Association and the American Medical Association; Fellow of the American College of Surgeons. Dr. Tuckerman's practice in the Cleveland area before his retirement extended over 60 years. He was a former secretary and past president of the Academy of Medicine of Cleveland, and a former trustee of the Cleveland Medical Library Association. During his lifetime, he participated in numerous civic activities in the Cleveland area. Two physician sons are Dr. Jacob B., and Dr. Warner W. Tuckerman, both of Cleveland. Also surviving are his widow, two daughters, another son, and a sister.

James E. Verbryke, M.D., Cincinnati; University of Cincinnati College of Medicine, 1945; aged 45; died February 11; member of the Ohio State Medical Association, the American Medical Association, and the American College of Cardiology. A practitioner in the field of internal medicine, Dr. Verbryke was physician also for the Southern Railway System. He was a member of the Catholic Church, the Knights of Columbus, and the Holy Name Society. Survivors include his widow, three daughters, three sons, and two brothers.

The Ohio Medical Education Network (OMEN) of the Ohio State University College of Medicine has received a \$5,000 grant from Merck Sharp & Dohm.

The number of veterans hospitalized for emphysema and chronic bronchitis, lung diseases common to the aging, has more than doubled in eight years, the Veterans Administration reports.

County Society Officers' Conference . . .

Association is Host to Officers and Committeemen of County Medical Societies; More than 140 Persons Gather in Columbus

MORE THAN 140 persons heard discussions on current topics of vital interest to the medical profession and to the public at the annual Conference of County Medical Society Officers and Committeemen. The meeting was held on Sunday, February 26 at the Fort Hayes Hotel in Columbus.

Purpose of the conference was to present up-to-date information on topics of current concern to the medical profession, and to provide an exchange of ideas between officers and committeemen on the county and state levels.

The Medical Practice Act

Dr. W. Thomas Washam, Executive Secretary of the State Medical Board of Ohio, discussed the Board's programs and activities, and gave considerable attention to proposed amendments to the Medical Practice Act sponsored by the Ohio State Medical Association.

Proposed amendments, now before the Ohio General Assembly, deal with such items as the following: Temporary certificates for physicians in training, such as interns and residents; limited licenses for certain physicians on staffs of state institutions; revision of the midwifery statutes; legal immunity for Board personnel when acting within the scope of their authority; authority for the Board to act in cases of incompetence or mental illness; strengthening of the grounds for refusal to grant, suspend, or revoke a license; increase in penalties for illegal practice; authority for injunction procedure against unlicensed practitioners; increase in the examination fee; biennial registration of doctors of medicine, so that the Board and the public will have an up-to-date list of licensed practitioners; and raising of the per diem allowance for the Board.

Dr. Washam discussed the necessity for many of the proposed amendments in view of the Board's responsibility in regard to licensing of practitioners and enforcing the Medical Practice Act. The Council of the OSMA has approved in principle the proposed amendments.

Accreditation

Dr. John D. Porterfield, director of the Joint Commission on Accreditation of Hospitals, with headquarters in Chicago, discussed the purposes and activities of that organization.

In what seemed a catchy title, "What Hospital Accreditation Is Not," Dr. Porterfield reassured persons who may have had misgivings or misunderstanding about the program. The speaker is no stranger to Ohio, since he was former director of the Ohio Department of Health, and later director of the Ohio Department of Mental Hygiene and Correction.

Following is an outline of points presented by Dr. Porterfield.

Accreditation is not licensure. (1) Licensure is issued in evidence of: Adequate facility; adequate equipment, adequate personnel with which to perform a quality service. (2) Licensure does not deal with performance and does not spell out performance standards. (3) Accreditation is documented evidence that this quality service has been rendered (operation one year).

Accreditation is not mandatory. (1) The surveyor comes only by invitation and looks for opportunities to be helpful in implementing the hospital's own choice to be accredited. (2) Inspectors, on the contrary, come without invitation or appointment and look for mistakes in relation to licensure.

Accreditation is not to be taken for granted.

Accreditation is not a hurdle to overcome every three years. The hurdler is on the same ground level after he recovers from his jump. Accreditation is a "jump" to an elevated platform of performance.

The Certificate of Accreditation is not the objective. Rather the objective is the ongoing performance of quality care for which the certificate is a symbol.

Accreditation is not based upon legalistic arbitrary interpretations of standards. Rather it is the measurement of documented performance in relation to quality. (1) Standards are frequently wrought out of the bitter experience of somebody. (2) Accreditation Standards are not divinely inspired and will change and be modified as experience teaches us safety and efficiency in relation to quality patient care. (3) Accreditation Standards are not made to make life miserable for doctors, but to assure the patient's safe place to go and get well and the doctor a safe place to practice medicine.

Medical Political Action

Dr. Jack Lewis, of Dayton, a member of the board of directors of the Ohio Medical Political Action



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Committee, discussed the functions and actions of OMPAC.

"The Strong Right Arm of Medicine," as OMPAC has been called, fills a function not legally open to organized medicine—that of raising and spending funds for political purposes, Dr. Lewis said. And the question naturally rises, he continued: How come we got along for so many years . . . and now must become so politically minded? There are two reasons: Not many years ago, it made little difference what political party was in power in Washington; when problems peculiar to medicine arose, medical associations were consulted. "As recent history has demonstrated," Dr. Lewis continued, "we not only were not consulted, but our unsolicited advice was roundly ignored."

The other reason has moral overtones. ". . . there is nothing sinful, wrong, or underhanded about an individual or an organization becoming involved in the business of running this country," he declared.

"Gentlemen, we are involved . . . Everyone of you that is apathetic to this problem is doing a vast disservice to your progeny and to the future generations in this country. . . you are extremely derelict if you are neuter in the matter of politics. This is not the day and age for political eunuchs."

Dr. Lewis pointed to the excellent record of OMPAC last year—the first time Ohio's strong right arm has been seriously put to the test.

In 1966 about 30 per cent of OSMA members made contributions to OMPAC and AMPAC. Contributions totalled approximately \$75,000. OMPAC made political contributions totalling \$67,350.

Of the total number of candidates for Congress and the Ohio General Assembly, OMPAC made financial contributions to 51. Of this number, 45 were elected. Financial contributions were made to the local support committees of ten candidates for the U. S. House of Representatives. Nine of these candidates were elected. Contributions went to committees of 14 candidates for the Ohio Senate and to 27 candidates for the Ohio House. Twelve of the Senators and 24 candidates for the House were successful.

A number of other successful candidates for the State Legislature, although not receiving financial support from OMPAC, did receive fine support from individual physicians, Dr. Lewis pointed out.

Dr. Lewis then went into a nuts-and-bolts discussion of how support is applied in a practical situation, using his own area as an example.

In conclusion, Dr. Lewis said: ". . . When the final judgment is written, let it be said that we tried to support intelligent, progressive solutions to our country's problems that would provide alternatives the completely paternalistic state. And let it further be said that here were men, at least, who were determined that the cause of freedom was not going to lose by default, nor for the want of a champion."

Additional Features

Dr. Lawrence C. Meredith, Elyria, President of the Association, presided during the morning session, and Dr. Robert E. Howard, Cincinnati, President-Elect, presided for the afternoon program.

An important part of the session was the Councilor District conferences, in which each of the 11 Councilors met with persons from his district for a discussion of topics of particular local interest. All of the 11 Councilors were present, as were other members of the OSMA Council.

A complimentary luncheon was enjoyed by all in Regency Ballroom of the Fort Hayes Hotel.

Following luncheon, Dr. Kenneth W. Clement, discussed Title XIX of the Medicare program. A practicing physician in Cleveland, Dr. Clement is a member of the Health Insurance Benefits Advisory Council to the Social Security Administration, and has attended numerous conferences pertaining to Medicare in Washington.

Dr. Clement discussed the various provisions of Title XIX and pointed out a number of changes that are being considered in Washington. He urged physicians to keep in close contact with developments in this field and to use their influence with congressmen to bring about favorable changes in the law.

Legislative Activities

"Medicine and Federal Legislation" was the topic of a talk presented by Aubrey D. Gates, director of the Field Service Division of the AMA. Mr. Gates discussed only a few of the many federal bills pending in Congress in regard to medical and health matters. He pointed out that in spite of the General Election's turn in favor of medicine's point of view, the real voting climate of Congress is still in doubt. He urged physicians to continue to keep close contact with their congressmen on the local level and to express their views especially in regard to government medical care programs. A number of State Medical Associations are holding conferences in Washington with their congressmen, as is the OSMA, Mr. Gates reported.

"Medicine and Ohio General Assembly Legislation" was the topic discussed by Hart F. Page, Executive Secretary of OSMA. Mr. Page discussed numerous bills with medical and health implications that are being introduced in the General Assembly. He reported that members of the OSMA staff are keeping close tab on all bills of interest. He urged physicians to keep in close contact with their representatives in the General Assembly, and to be ready to appear before Legislative Committee hearings if the occasion arises. As actions develop in the Legislature, Mr. Page said, information will be issued to members through *The Journal* and by direct mail as soon as official policy of The Council can be established.

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Activities of County Societies . . .

First District

(COUNCILOR: PAUL N. IVINS, M. D., HAMILTON)

BUTLER

A joint meeting of the Butler County Medical Society and the Keeley Dental Society was held in February at the Hamilton Elks Club hall. Members of both groups and wives enjoyed a buffet dinner in connection with the meeting.

Principal speaker for the occasion was Judge Benjamin S. Schwartz, of the Hamilton County Juvenile Court, who discussed growing law enforcement problems in regard to juveniles.

HAMILTON

Seven physicians, who have completed 50 years in the practice of medicine, were honored by the Academy of Medicine of Cincinnati and the Ohio State Medical Association.

They are Dr. Henry A. Springer, Dr. Joseph Katz, Dr. Ralph G. Carothers, Dr. Ira A. Abrahamson, Sr., Dr. Horace W. Reid, Dr. Thomas A. Ratliff, and Dr. James B. Falk, who is now deceased.

Taking part in presentation of the 50-Year Awards were Dr. Paul N. Ivins, First District Councilor, and Dr. Elmer R. Maurer, Academy president.

* * *

The Academy of Medicine of Cincinnati had as guest speaker on February 21, Dr. John V. Kinross-Wright, director of the Houston State Psychiatric Institute, Houston, Texas. His topic was "Tranquilizers, Use and Misuse."

Third District

(COUNCILOR: FREDERICK T. MERCHANT, M. D., MARION)

ALLEN

Dr. John L. Terry, associate professor of surgery at Ohio State University College of Medicine, was principal speaker for the February 21 dinner meeting of the Academy of Medicine of Lima and Allen County, held in the Milano Club, Lima. He discussed reconstructive breast surgery.

Fourth District

(COUNCILOR: ROBERT N. SMITH, M. D., TOLEDO)

LUCAS

The Surgical Section of the Academy of Medicine of Toledo and Lucas County sponsored a program on February 10 entitled "Ulcerative Colitis: Two Diseases?" Principal speaker was Dr. Rupert Turn-

bull, head of the Department of Colon and Rectal Surgery, Cleveland Clinic. The meeting, held at the Academy Building, was preceded by a buffet dinner.

On February 24, the Toledo Obstetrical-Gynecological Society and the Toledo Anesthesia Society jointly sponsored a program at the Academy building, entitled "Anesthesia Problems in Obstetrics and Gynecology."

The Academy and the Auxiliary jointly sponsored the annual dinner-dance at Le Cafe Moulin Rouge, of the Sylvania Country Club on February 25.

Sixth District

(COUNCILOR: EDWIN R. WESTBROOK, M. D., WARREN)

MAHONING

Dr. Jack Schreiber, a general practitioner in Canfield and a member of the Mahoning County Medical Society, has been named a recipient of a Freedoms Foundation medal and cash award.

Dr. Schreiber was honored for his speech, "The Last Candle," which he has delivered on a number of occasions. He had not known that the speech was being submitted to the Freedoms Foundation.

In presenting his talk, Dr. Schreiber illustrates it with a bit of magic involving disappearing lighted candles. "The Last Candle" to disappear is the one representing the individual's responsibility to provide for himself to the best of his ability.

Presentation of the award was scheduled to take place at a coming Foundation meeting. Eight other schools or individuals in the Youngstown area were named medal winners.

* * *

The scientific portion of the February 21 meeting of the Mahoning County Medical Society was a presentation on Sigmoidoscopy by Dr. David B. Brown. A film on the subject was shown by Mr. Carl Holzbach, executive director of the Mahoning Cancer Society.

The annual dinner-dance took the form of a Viennese Ball, sponsored by both the Medical Society and the Auxiliary, and held at the Squaw Creek Country Club on February 25.

TRUMBULL

Clayton L. Scroggins, Cincinnati, head of the management consultant firm which bears his name, was speaker for the February 15 meeting of the

Trumbull County Medical Society at the Trumbull Country Club, Warren. His topic was "The Future of Medical Practice."

Tenth District

(COUNCILOR: RICHARD L. FULTON, M. D., COLUMBUS)

DELAWARE

Delaware County Medical Society at its recent meeting showed the American Cancer Society film that explains the physical examination for detection of cancer of the colon and rectum. Dr. Robert Caulkins, professional education chairman of the cancer society, sponsored the film showing. — *Sunbury News*.

Eleventh District

(COUNCILOR: WILLIAM R. SCHULTZ, M. D., WOOSTER)

LORAIN

The regular meeting of Lorain County Medical Society was devoted to business affairs, when members met at Oberlin Inn on February 14.

President R. S. VanDervort, M. D., called the members' attention to the AMA House of Delegates' Resolution concerning utilization of retired physicians and inactive nurses.

Otto Schales, D. Sc. (Elyria) was unanimously accepted into "Affiliate" Membership in the Society, and Sami A. Sfeir, M. D. (Lorain) into "Associate" Membership. The membership unanimously elected Charles G. Adams, M. D. (Vermilion), and Pacifico C. Mercado, M. D. (Elyria) "Active" Members.

The matter of Utilization and Review Committees to serve Extended Care Facilities came under discussion, and reports were heard concerning present policy in three accredited facilities in Lorain County. The Executive Secretary reported on the results of enquiry made through the District Office of the Social Security Administration relative to the possibility of payment to physicians who serve on such committees. Following deliberations, it was moved,

seconded, and unanimously approved by those members present and voting, that:

(a) Lorain County Medical Society go on record as opposing appointment of a Utilization Committee on a county-wide level, to serve Extended Care Facilities, but that each Facility should approach individual physicians.

(b) That the Society go on record as opposing any attempts by Medicare officials to pay for services of such Utilization Committees.

The subject of Nursing Education Programs also came under discussion relative to the shortage of nursing personnel. It was stated that the high standard of nursing required by Accredited Hospitals demonstrates that the two-year college course is often insufficient — without further training in "floor" experience — to produce acceptably qualified nursing personnel.

Quoting the American Medical Association standards that nurses should not receive training in Non-Certified Hospitals, a physician emphasized that these standards are violated when nurses are trained in substandard hospitals. A motion was presented, seconded, and unanimously carried by members present and voting, that:

Lorain County Medical Society go on record as favoring the three-year Diploma Training Program for Nurses.

Toledo EENT Society Announces Annual Seminar, April 30

The Toledo Eye, Ear, Nose, and Throat Society announces its annual seminar to be held on Sunday, April 30, 1967. The guest speakers will be Bruce Fralich, M. D., F.A.C.S., of Ann Arbor, Michigan, and Bruce Proctor, M. D., F.A.C.S., of Royal Oak, Michigan. The meetings will be held at the Academy Building in Toledo, Ohio. For information write N. Gardner Mathieson, M. D., at 316 Michigan Street, Toledo, Ohio 43624.

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Woman's Auxiliary Highlights...

By MRS. S. L. MELTZER, Chairman, Publicity Committee

2442 Dorman Drive, Portsmouth 45662

MAYBE I'm indulging in flights of fancy and wishful thinking, but I honestly feel that if each and every Ohio auxiliary member were polled and asked: "What would you consider the compliment supreme as an auxiliary member?" her answer would be: "Recognition by the doctors that we are doing a good and important job for the medical profession."

That the doctors do think so—and have given us the compliment supreme—is evidenced in this latest news flash: For the first time, members of the Woman's Auxiliary to the Ohio State Medical Association have been invited to attend the Formal Session of the OSMA House of Delegates at the Sheraton-Columbus Motor Hotel, in downtown Columbus, on Tuesday, May 16, from 2:30 to 4:30 P. M.

It was just last year that, for the first time, we were invited to join the doctors in their General Sessions. Again this year that privilege has been accorded us. We are deeply aware of the significance of these actions of the Ohio State Medical Association. That the doctors recognize in the Woman's Auxiliary a vital and dedicated force, eager and able to serve the profession, is something we cherish very much indeed. Thank you, gentlemen, for your confidence in us.

Coming up in May is the Auxiliary's 27th annual meeting. You already know that it will be in Columbus. The specific dates are Tuesday, May 16; Wednesday, May 17; Thursday, May 18; and Friday, May 19. Headquarters—The Neil House. Mrs. Samuel Saslaw (Franklin County) is convention chairman, with Mrs. Floyd Beman serving as her cochairman. No two women ever have a tougher, more exacting job on their hands than those who serve each year as convention chairmen. Too many of us are likely to take their services for granted. So when you come to convention this year, give more than a passing thought to the two women who have been carrying on, with everything they've got, for many, many months of planning—and worrying!

In place of the traditional Doctors' Day luncheon, the Auxiliary has been asked to join OSMA at the OMPAC luncheon at the Sheraton-Columbus to hear Ohio's U. S. Representative, the Honorable John M. Ashbrook, speak on "The Role of the Physician in Politics." (Tickets for the luncheon—five dollars each).

The Formal Session of the OSMA House of Delegates will follow this luncheon. Dr. Lawrence C. Meredith, President, will address the delegates on his year 1966-67; Dr. Robert E. Howard, President-Elect,

will deliver his inaugural talk; Dr. Charles L. Hudson, AMA President, will report on the national body; and Mrs. James N. Wychgel, Ohio's auxiliary president, will present a resume of her stewardship (and we know she has much to be proud about!). Visiting dignitaries and the 88 county medical society presidents will be honored and the Montgomery Medical Society Glee Club will provide entertainment. Immediately following the Formal Session, OSMA will host a cocktail party from 4:30 to 6:00 P. M.

Auxiliary Sessions

The Auxiliary will hold three House of Delegates sessions on Wednesday, Thursday, and Friday mornings from 9:00 to 11:30 A. M. Mrs. Karl Ritter, National president-elect and Ohio's very special guest, will report on her plans for 1967-68 at one of the sessions. Mrs. Willard C. Scrivner, north-central regional vice-president of the National Auxiliary, will install the new officers on Friday morning. Since legislation has been our No. 1 priority this year, what could be more fitting and natural than to have, as Thursday morning speaker, Mrs. C. A. Swanbeck, auxiliary member, who last November was elected to her seventh House term in the Ohio Legislature? A salute to this capable and charming doctor's wife! (She is a past president of the Erie County auxiliary and a former member of the State Board as Eleventh District director.)

There will again be the very popular individual two-minute reports from county presidents on Wednesday afternoon at The Neil House from 3:30 to 5:00 P. M. This year, Mrs. Wychgel has asked the local presidents to highlight one special meeting or project. On Thursday afternoon, Mrs. Paul Sauvageot, president-elect, will conduct a School of Instruction that will feature Mrs. Rudolf O. Cooks, on Parliamentary Procedure (which was so enthusiastically received at Fall Conference!) Voting on the 1967-68 slate will also take place from 3:00 to 5:30 P. M. that afternoon.

Thursday night will be fun night! What? The Gaslight Party! Where? The Neil House. When? 7:00 P. M. 'till . . . ??? (That's up to you!) There will be Gay Nineties overtones and there will even be special tables for "escortless" ladies . . . (Naturally, tables for ladies lucky enough to come up with an escort!!) Five-cent beer will be back for the night as will an old-fashioned pickle barrel, giant cheese wheels, cold sauerkraut, stuff with which to "create" sandwiches and—well more of "all that thar" . . . Entertainment will feature The Gaslight Road Show

(direct from Chicago's Gaslight Club), the Keystone Brothers (piano and banjo) and The Al Myers' Quartet (Dixieland). All this — and more — for just eight dollars per person.

A luncheon will follow each of the three morning Auxiliary House of Delegates sessions (female of the species, only). The luncheons will be from 11:45 A. M. to 1:00 P. M. Wednesday's will honor county presidents, presidents-elect and visiting dignitaries. Thursday's will pay tribute to State and National Past Presidents and visiting dignitaries. Friday's will pay tribute to the newly elected officers and board members, with the Summit county group hosting a Sherry Party preceding this buffet-type luncheon. On each of these three days, there will be buses available to take us from The Neil House to Veterans Memorial Building for the 1:30 P. M. OSMA General Sessions.

New Feature

The "something new" at this auxiliary convention will be the organization's first Hobby Show. Members are being urged to participate in the exhibition of their creative arts. According to Ruth Wychgel, "we have authors, artists in many fields, experts in knitting, crewel embroidery, needlepoint, wood carving, jewelry making, ceramics, and so on." Mrs. Wychgel urges: "Don't hide your talent — share it with us." For space and further information, contact Mrs. William Rigsby, 1844 Barrington Road, Columbus 43221. For space for county scrapbooks and other displays, your contact is Mrs. Fred Rose, 174 Croswell Road, Columbus.

Registration and all Auxiliary meetings will be held at The Neil House on the MEZZANINE floor. The Hospitality Room will be housed there, as will the above-mentioned Hobby Show and Exhibits. Franklin County (bless those gals!) will again provide the convention committees so important to Mrs. Saslaw and Mrs. Beman. Mrs. James Conn, Franklin County president, will serve as Credentials Chairman. PLEASE — get busy on your room reservations at The Neil House, if you haven't already done so. You will love the "New Look" of this famous old Columbus hostelry which has had a recent and most effective rejuvenating job. And while, of course, most of your time will be taken up with Auxiliary and OSMA matters, it is nice to know that within very easy walking distance are those certain places into which one can dash in in-between free moments . . . Just a thought!

To those of you on the STATE BOARD, there will be a Tuesday morning meeting from 10:00 to 12:00 A. M. The Board dinner will be held Tuesday evening at 7:00 P. M.

Speakers

The distinguished speakers at the OSMA General Session on Wednesday will be: Mary S. Calderone, M. D., New York City Executive Director, Sex Information and Education Council of the United

States, who will discuss "Educating Patients About Sexual Relationships"; and Alan F. Guttmacher, M. D., New York City President, Planned Parenthood Federation of America, who will discuss "Contraceptive Problems in Medical Practice." Thursday's session will feature a Panel Discussion on "Drug Regulations and Compulsory Generic Prescribing" at which Perry R. Ayres, M. D., Editor of the *Ohio State Medical Journal*, will serve as moderator, with these participants: Max S. Sadove, M. D., of Chicago, professor and head of the Department of Anesthesiology, University of Illinois Research and Educational Hospitals and professor and head of the Division of Anesthesiology, University of Illinois College of Medicine; and C. Joseph Stetler, Washington, D. C., President, Pharmaceutical Manufacturers Association. And Friday's *piece de resistance* will be the presence of Milford O. Rouse, M. D., of Dallas, Texas, President-Elect, the American Medical Association, who will discuss many matters of much importance.

Around the State

The Allen County group held its January meeting at the home of Mrs. S. J. Novello, with mental health the feature of the day. Speakers included: Mr. Robert Rease, public relations director, St. Rita's Hospital; and Mrs. Sue Vogt, mental health and social service coordinator. They discussed tentative

(Continued on Page 568)

PLAN A

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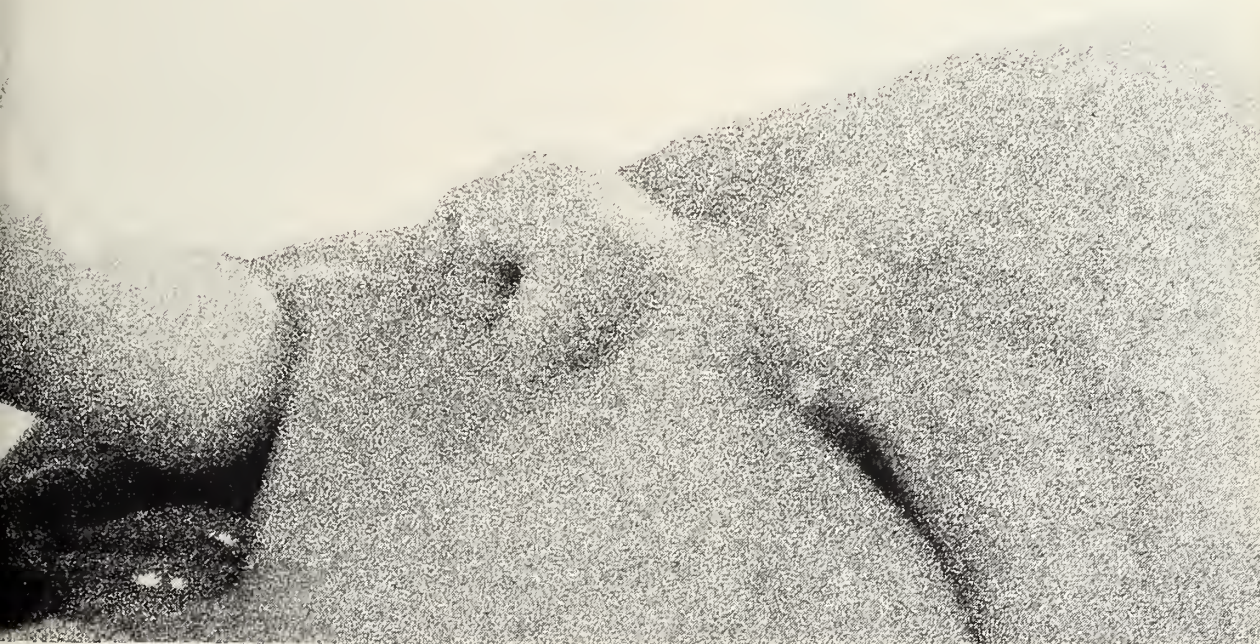
1. Carson, M., and Hart, L.: "New Perspectives on Nutritional Aspects of Modified Milk-Fat Formulas," Colloquium held under the auspices of The Pediatric Department, Western Reserve University School of Medicine at Cleveland, Ohio, Sept. 8, 1966. Data available on request.

2. Hepner, R.; *ibid.* 3. Nichols, M.; *ibid.* 4. McCann, M.L.; Teree, T., and Wallace, W.; *ibid.*

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plans for a 37-bed psychiatric ward to be located in the new wing of the hospital (to be opened in the Spring). Another speaker was Mrs. Martin Sondheimer, president of the Allen County Mental Health Association who told of the change in name and new address of the Northwest Mental Health Center now located in the Civic Building, with services available for both adults and children. She also discussed the work of her organization in promoting mental health programs and in pushing forward to reality the hoped-for Comprehensive Mental Health Center. A film, "Mental Health in Children," was shown.

The February meeting turned the spotlight on "Inside Our Community Theater," a fascinating program presented by Mr. Robert Fronterhouse who is director of the Encore Theater. The semicircular stage (used originally by the Greeks) makes it possible to produce all styles of drama, from Shakespeare to modern. He spoke of light control as "the music of the theater" because it sets the mood. Members were taken back stage to get a first-hand look at behind-the-scenes activities.

The Hamilton County auxiliary had an informative February luncheon meeting when Newspaper Problems were discussed by Brady Black, vice-president and editor of *The Cincinnati Enquirer*. New

auxiliary members were invited as guests and were welcomed by Mrs. Robert S. Heidt, orientation chairman, and Mrs. George Griffin, vice-chairman. Also invited as special guests were the wives of foreign doctors serving internships and residencies in Cincinnati hospitals. Mrs. John D. Marioni, international hospitality chairman, introduced these 22 guests who represented 16 countries — Arabic, Persian, Polish, Spanish, Basque, Dutch Flemish, French, Tagalog, Urdu, Japanese, and German.

Mrs. Marioni and her committee members, Mrs. Donald B. Nicholson and Mrs. F. L. Mendes, Jr., work as volunteers with the International Visitors Center, concentrating their efforts on the group coming to study medicine on special visas. These foreign visitors find the Center a haven of welcome and assistance. Many of these young women are also active in house staff clubs of their husbands' respective hospitals.

That Convention

Show your appreciation of what Ruth Wychgel and Ludel Sauvageot are doing for your State Auxiliary by marking your calendars NOW — for that all important annual meeting May 16, 17, 18, and 19. Your interest and your participation can make limitless the important avenues your Auxiliary travels!

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BUTLER—Brady Randolph, President, 128 North Front Street, Hamilton 45011; Mr. Charles G. Greig, Executive Secretary, 110 North Third Street, Hamilton 45011. 3rd Wednesday monthly.

CLERMONT—Noco Capurro, President, 481 Craig Road, Cincinnati 45244; Phillips F. Greene, Secretary, Route 1, Box 509, New Richmond 45157. 3rd Wednesday monthly except July, August, and December.

CLINTON—H. Richard Bath, President, 290 West Main Street, Wilmington 45177; Mary R. Boyd, Secretary, Box 629, Wilmington 45177. 4th Tuesday monthly.

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HIGHLAND—Thomas L. Jones, President, 528 South Street, Greenfield 45123; Glenn B. Doan, Secretary, 614 Jefferson Street, Greenfield 45123.

WARREN—George A. Rourke, President, 210 Mound Street, Lebanon 45036; Ray E. Simindinger, Secretary, 901 North Broadway Street, Lebanon 45036. 2nd Tuesday monthly.

Second District

Councilor: Theodore L. Light, Dayton 45406
2670 Salem Ave.

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CLARK—H. B. Elliott, President, 25 West Harding Road, Springfield 45504; Mrs. Marion L. Wilcoxson, Executive Secretary, 616 Building, Room 131, 616 North Limestone Street, Springfield 45503. 3rd Tuesday monthly.

DARKE—E. Westbrook Browne, President, 330 West 4th Street, Greenville 45331; Giles Wolverton, Secretary, Darke County Department of Public Health, Court House, Greenville 45331. 3rd Tuesday monthly.

GREENE—Richard A. Falls, President, 1148 North Monroe Drive, Xenia 45385; Mrs. C. K. Elliott, Executive Secretary, 225 Pleasant Street, Xenia 45385. 2nd Thursday monthly, except July and August.

MIAMI—Robert L. Sutton, President, 423 West Main Street, Tipp City 45371; Robert J. Price, Secretary, 760 North West-edge Drive, Tipp City 45371. 1st Tuesday monthly.

MONTGOMERY—W. J. Lewis, President, 2567 Far Hills Avenue, Dayton 45419; Mr. Robert F. Freeman, Executive Secretary, 280 Fidelity Medical Building, Dayton 45402. 1st Friday monthly.

PREBLE—John D. Darrow, President, 228 North Barron Street, Eaton 45320; J. R. Williams, Secretary, 228 North Barron Street, Eaton 45320. December yearly.

SHELBY—George J. Schroer, President, 322 Second Avenue, Sidney 45365; Alfonsas Kisielius, Secretary, Ohio Building, Sidney 45365.

COUNTY SOCIETIES' OFFICERS AND MEETING DATES (Continued)

Third District

Councilor: Frederick T. Merchant, Marion 43305
1051 Harding Memorial Pky.

ALLEN—T. L. Edwards, President, 670 West Market Street, Lima 45801; T. D. Allison, Secretary, 401 Metropolitan Bank Building, Lima 45801. 3rd Tuesday monthly (omitting June, July, and August).

AUGLAIZE—R. S. Sobocinski, President, 7 South Blackhoof Street, Wapakoneta 45895; J. F. Bowling, Secretary, 319 West Spring, St. Marys 45885. 1st Thursday odd months, with exception of July.

CRAWFORD—Carl Ide, President, 140 Hill Street, Bucyrus 44820; Roy Wildey, Secretary, 130 Hill Street, Bucyrus 44820. Meetings held on call.

HANCOCK—Joseph G. Barkey, President, 120 West Foulke Street, Findlay 45840; Carson P. Cochran, Secretary, 1725 South Main Street, Findlay 45840. 3rd Tuesday monthly.

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LOGAN—G. E. Munn, President, 120 East Sandusky Street, Bellefontaine 43311; J. Terebuh, Secretary, Colonial Arms Apt. 10, Bellefontaine 43311. 1st Friday monthly.

MARION—Richard W. Mills, President, 170 Fairfax Road, Marion 43302; Alice F. Fisher, Secretary, 1040 Delaware Avenue, Marion 43302. 1st Tuesday monthly.

MERCER—Cecil E. Pennington, President, 406 South Oak, Coldwater 45828; George H. McIlroy, Secretary, 123 East Fayette Street, Celina 45822. 3rd Thursday monthly.

SENECA—Lowell K. Good, President, 133 West North Street, Fostoria 44830; W. F. Yarris, Secretary, 301 Perry Street, Fostoria 44830. 3rd Tuesday every other month.

VAN WERT—Wilmer L. Iler, President, Medical Arts Building, Fox Road, Van Wert 45891; Fred E. Culler, Secretary, 938 South Washington Street, Van Wert 45891. 4th Friday monthly.

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Councilor: Robert N. Smith, Toledo 43606
3939 Monroe St.

DEFIANCE—George L. Boomer, President, 1075 East Second Street, Defiance 43512; Miss Lois Coffin, Executive Secretary, P. O. Box 386, Defiance 43512. 1st Saturday monthly.

FULTON—F. E. Elliott, President, 203 Beech Street, Wauseon 43567; R. L. Davis, Secretary, 137 South Fulton, Wauseon 43567. Quarterly, March, June, September, and December, 2nd Tuesday.

HENRY—T. F. Moriarty, President, Napoleon 43545; Wilson J. Stough, Secretary, Napoleon 43545. 1st Tuesday monthly.

LUCAS—George T. Booth, President, 1006 Secor Hotel, Toledo 43603; Mr. Robert W. Elwell, Executive Secretary, 3101 Collingwood Boulevard, Toledo 43610. Council meets on 3rd Tuesday of each month except July and August.

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SANDUSKY—E. C. Hiestand, President, Old Fort 44861; Mrs. Patsy J. Askins, Executive Secretary, Central Office, Memorial Hospital of Sandusky County, Fremont 43420. 3rd Wednesday monthly.

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Fifth District

Councilor: P. John Robeck, Cleveland 44106
10525 Carnegie Ave.

ASHTABULA—S. E. Gates, President, 344 State Street, Conneaut 44030; A. R. DeCato, Secretary, 3903 Lake Avenue, Ashtabula 44004. 2nd Tuesday monthly.

CUYAHOGA—David Fishman, President, Room 404, 10515 Carnegie Avenue, Cleveland 44106; Mr. Robert A. Lang, Executive Secretary, 10525 Carnegie Avenue, Cleveland 44106.

GEAUGA—C. K. Adrian, President, Medical Arts Building, 18221 Ravenna Road, Chardon 44024; Mrs. Martha Withrow, Executive Secretary, P. O. Box 249, Chardon 44024. 2nd Friday monthly.

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438 North Park Ave.

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SUMMIT—L. V. Phillips, President, 2106 Braewick Circle, Akron 44313; Mr. S. H. Mountcastle, Executive Secretary, 430 Grant Street, Akron 44311. 1st Tuesday monthly.

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Seventh District

Councilor: Sanford Press, Steubenville 43952
525 North Fourth Street

BELMONT—D. M. Creamer, President, First National Bank Building, Bellaire 43906; Bertha M. Joseph, Secretary, Myers Building, Martins Ferry 43935. 3rd Thursday monthly, except January, May, July, and August.

CARROLL—P. S. Whiteleather, President, Minerva 44657; T. J. Atchison, Secretary, 292 East Main Street, Carrollton 44615. 2nd Tuesday monthly, except July and August.

COSHOCTON—Donald E. Potts, President, 600 East Main Street, West Lafayette 43845; H. W. Lear, Secretary, 345 South 4th Street, Coshocton 43812. 2nd Tuesday monthly.

HARRISON—Charles Evans, President, 159 South Main Street, Cadiz 43907; G. E. Vorhies, Secretary, Scio 43988. 3rd Wednesday, March, June, September and December.

JEFFERSON—Lee A. Rosenblum, President, 114 Brady Circle, E., Steubenville 43952; Raymond B. Cagina, Secretary, 909 3rd Street, Brilliant, Ohio 43913. 4th Tuesday monthly except no meeting in December, January, and February.

MONROE—Byron Gillespie, Secretary, Woodsfield 43793.

TUSCARAWAS—James F. Zeller, President, 250 West High Avenue, New Philadelphia 44663; C. Raymond Crawley, Secretary, 232 West Third Street, Dover 44622. 2nd Wednesday or Thursday monthly.

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Councilor: Robert C. Beardsley, Zanesville 43705
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4th & Sycamore St.

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MEIGS—Charles J. Mullen, President, 210½ East Main Street, Pomeroy 45769; E. Butrimas, Secretary, 204 East Main Street, Pomeroy 45769. Meetings as needed.

PIKE—A. M. Shrader, President, 196 Emmitt Avenue, Waverly 45690; Janie Hwang, Secretary, 400 Cherry Street, Waverly 45690. 1st Tuesday monthly.

SCIOTO—Chester H. Allen, President, 1405 Offnere Street, Portsmouth 45662; Ericb Spiro, Secretary, 1735 Waller Street, Portsmouth 45662. February, April, July, October, and December (may be changes).

VINTON—Richard E. Bullock, President, 203 South Market Street, McArthur 45651.

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Councilor: Richard L. Fulton, Columbus 43212
1211 Dublin Rd.

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KNOX—Richard L. Smythe, President, 812 Coshocton Avenue, Mount Vernon 43050; Robert E. Sooy, Secretary, 812 Coshocton Avenue, Mount Vernon 43350. 1st Wednesday monthly, except July and August.

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MORROW—Lowell Murphy, President, 209 South Marion Street, Cardington 43315; David James Hickson, Secretary, 712 Baker Street, Mt. Gilead 43338. 1st Tuesday monthly, 6:30 P. M. dinner

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ROSS—Richard L. Counts, President, 56 East Second Street, Chillicothe 45601; Walter Kramer, Secretary, 39 West Main Street, Chillicothe 45601. 1st Thursday monthly.

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1749 Cleveland Road

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ERIE—W. P. Skirball, President, 1218 Cleveland Road, Sandusky 44870; Mrs. David Wolfert, Executive Secretary, 1428 Hollywood Road, Sandusky 44870. 2nd Tuesday monthly.

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HURON—Richard L. Jackson, President, 15 East Emerald Street, Willard 44890; John Rosso, Secretary, 218 Myrtle Avenue, Willard 44890; 2nd Wednesday of February, April, June, August, October, and December.

LORAIN—Robert S. VanDevort, President, 230 Hamilton Avenue, Elyria 44035; Mrs. Gladys Davidson, Executive Secretary, 428 West Avenue, Elyria 44035. 2nd Tuesday monthly, except June, July, and August.

MEDINA—B. A. Kassel, President, 750 East Washington Street, Medina 44256; Mr. A. Dana Whipple, Executive Secretary, 320 East Liberty Street, Medina 44256. 3rd Thursday monthly.

RICHLAND—Wendell M. Bell, President, 480 Glessner Avenue, Mansfield 44903; Mrs. M. K. Leggett, Executive Secretary, Mansfield General Hospital, Mansfield 44903. 3rd Thursday monthly.

WAYNE—Lyle Moyer, President, Dalton 44618; R. J. Watkins, Secretary, 1736 Beall Avenue, Wooster 44691. 2nd Wednesday, alternate months.

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The OHIO STATE MEDICAL Journal



VOL. 63 MAY, 1967 NO. 5

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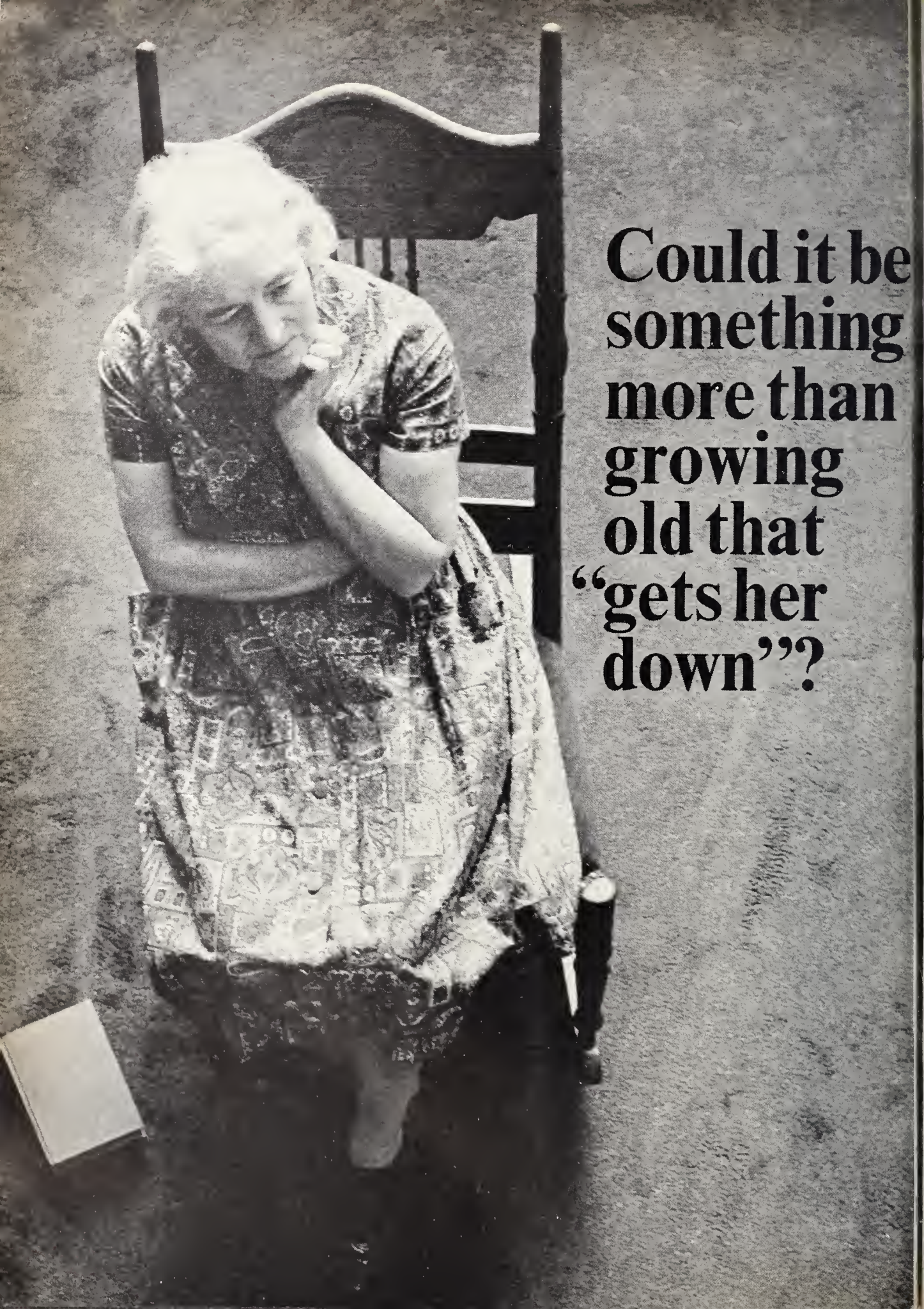
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Fiscal Year Deadline Is Set for Hill-Burton Aid Requests

A recent communication was forwarded to hospital and medical facilities administrators and health commissioners of Ohio by Dr. Emmett W. Arnold, director of the Ohio Department of Health, on the subject, "Medical Facilities Construction Programs for the Fiscal Year 1967-1968." The communication reads as follows:

Hospitals, nursing homes, health departments, rehabilitation centers or related medical facilities that are planning construction or remodeling in the next fiscal year which starts July 1, 1967, and are planning to request Federal assistance under the Hill-Burton program should be giving consideration to filing a request form.

Preliminary request forms and instructions are available in the office of the Division of Medical Facilities of the Ohio Department of Health. Copies may be obtained by writing to: Mr. William S. Wolfe, Chief, Division of Medical Facilities, Box 118, Columbus, Ohio 43216.

Attention is called to the policy in the Ohio State Plan for Hospital and Medical Facilities Construction of the deadline filing date of June 15, 1967 of request for consideration in the next fiscal year. Ap-

plications will be reviewed after the approval of the 1967-68 annual revision of the State Plan.

Dr. Arnold suggests that any questions regarding this program be directed to the Division of Medical Facilities at the foregoing address.

Education Review Committee Headed by Physician

A physician was selected by Governor James A. Rhodes to head the newly created State Supported Education Review Committee, a bipartisan group whose chief aim is to recommend legislation toward providing "equalization of educational opportunity" throughout Ohio.

Named chairman of the committee is Dr. John C. Ullery, chairman of the Department of Obstetrics and Gynecology of the Ohio State University College of Medicine, since 1954. Dr. Ullery, is a native of Bradford, Ohio, a former Buckeye gridder (1925-1927) and a graduate of Jefferson Medical College of Philadelphia.

The committee he heads is composed of 17 members including the chairman — four legislators, five educators, and seven other persons. Its recommendations to the Ohio General Assembly will incorporate features of reports of the Ohio School Survey Committee, the Master Plan of School District Reorganization, and the Ohio Tax Study Commission.

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Ohio State Heart Association Schedules Program May 18

Dr. Oglesby Paul, past president of the American Heart Association and chief of the Division of Medicine, Passavant Memorial Hospital, Chicago, will be luncheon speaker at the annual meeting of the Ohio State Heart Association on May 18 at the Fort Hayes Hotel in Columbus.

Dr. Paul was a member of a committee which spent more than a year in a study of the organization of the Heart Association and has recommended structural changes to permit greater efficiency in operation. His subject will be "The Heart Association in an Era of Change."

Campbell Moses, M.D., medical director of the American Heart Association, will deliver the keynote address to open the meeting.

Theme of the annual meeting will be "Looking Ahead" and Dr. Simon Koletsky of Cleveland, chairman of the State Research Review Committee, will moderate the panel on "Looking Ahead in Research."

Discussants on the Research panel will be Dr. Roland E. Schneckloth, director of research of the American Heart Association; Dr. Richard W. Booth, director of the Cardiac Center, Omaha; and Dr. Peter Frommer, deputy chief, Medical Branch of the National Heart Institute.

Discussants on the panel "Looking Ahead in Programming" will be Dr. Jean-Maurice Poitras, chief

of the Rheumatic Fever Section, Heart Disease Control Program, National Center for Chronic Diseases, U. S. Public Health Service; Dr. Donald Vincent, assistant clinical professor of medicine, Ohio State University; and Dr. Campbell Moses. Jack S. Silberstein, M. D., will be moderator.

The Ohio State Heart Association is also presenting a scientific program on Wednesday, May 17, as a feature of the Ohio State Medical Association Annual Meeting.

Course in Roentgenology Offered In Cincinnati, May 22-27

The eighth annual Refresher Course in Diagnostic Roentgenology will be held by the Radiology Department of the University of Cincinnati College of Medicine under the direction of Dr. Benjamin Felson, May 22-27.

In addition to lectures and demonstrations, the course will include teaching methods employing audience participation. Saturday, May 27, will be devoted entirely to radiation physics because of the desires of many former participants.

Further information concerning the course, which is open to radiologists and radiology residents, may be obtained by writing Dr. Jerome F. Wiot, Department of Radiology, Cincinnati General Hospital, Cincinnati, Ohio 45229.

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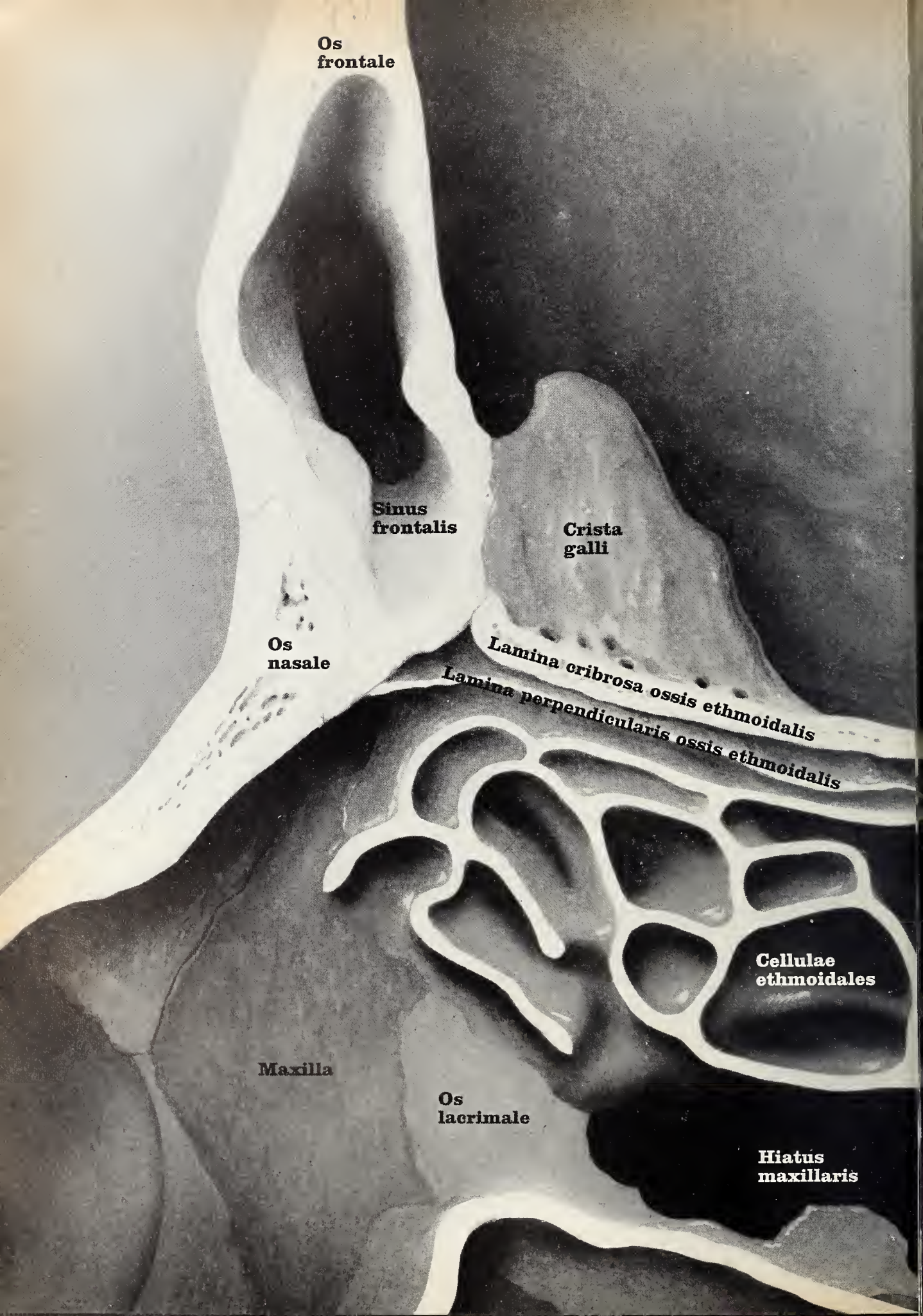
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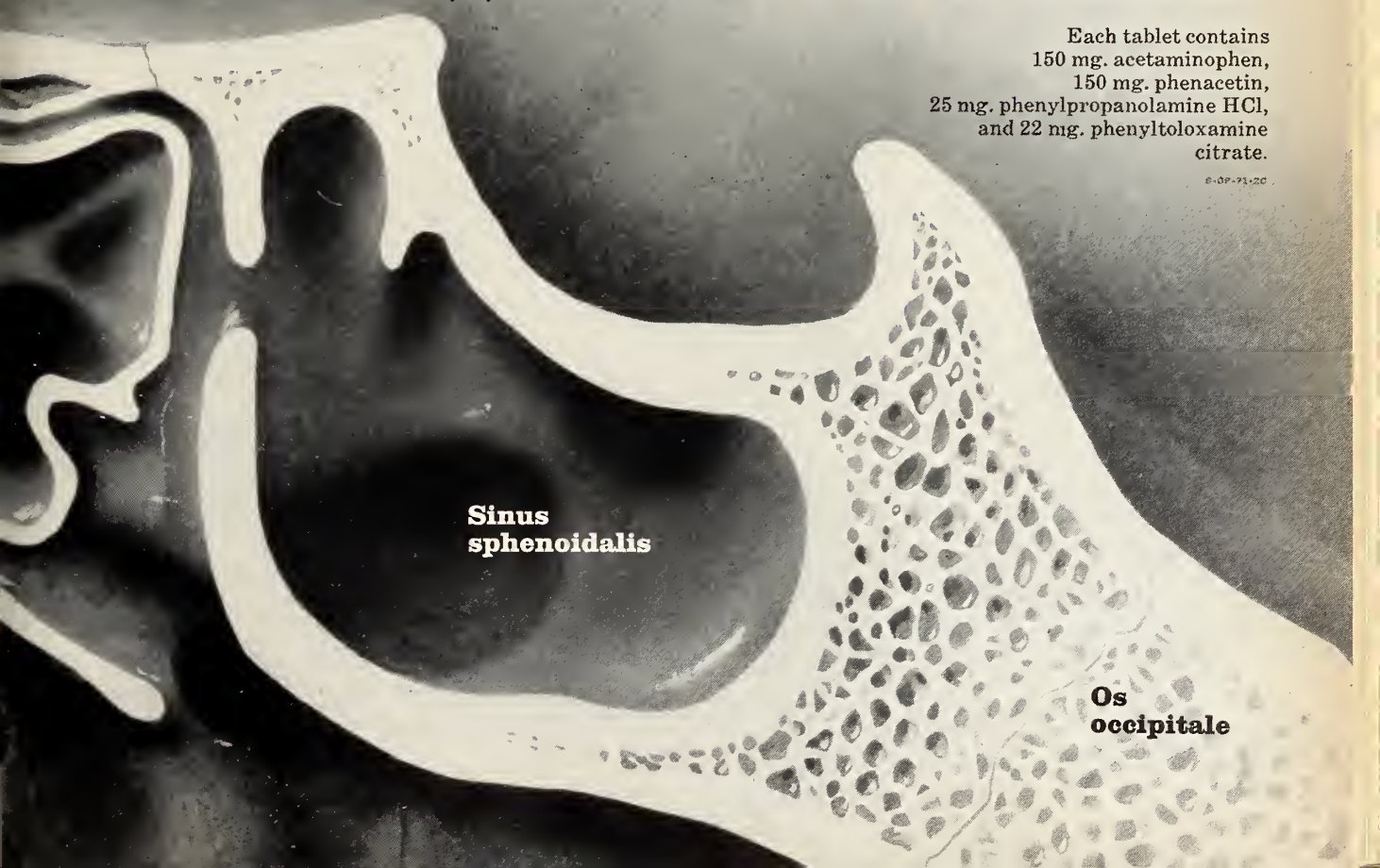
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Health Officers of Cincinnati, Ohio And the Problems of Their Day

1900 to 1960

KENNETH I. E. MACLEOD, M. D., M. P. H.*

PART XI

(Conclusion)

Annual Report — 1953 Highlights

DISCUSSING "Life's Two Extremes" in the issue of CINCINNATI'S HEALTH dated January 1, 1954, Dr. Carl A. Wilzbach noted that "the vast majority of deaths occur among the very young and in oldsters 70 years and above." He notes also that

in spite of better obstetrical, hospital, and nursing care, as well as continued emphasis on prenatal education for expectant mothers, many needless deaths still occur . . .

Between the turn of the century and 1960 the crude death rate in the country dropped from 17.2 to 9.5 per 1,000 population — a decrease of 45 per cent — but lest we congratulate ourselves too quickly, it should be also observed that had we applied more rigorously all of our knowledge and left no stone unturned to reach the lowest socioeconomic groups with the aids of modern science, we might have emulated certain other smaller countries and attained an even greater success. Indeed it has been calculated that if we did as well as the Scandinavian countries, Holland, and New Zealand, the crude death rate might have been as low as 7.3 per 1,000 population. [K. I. E. M.]

In 1953 the Health Department's new Muhlberg Health Center, located in the Cumminsville-Northside-College Hill area was started, funded with the \$150,000 provided by the 1948 city bond for this project.

Also in 1953, industrial health studies were conducted by the Health Department "in several plants where hazardous exposure included lead dust, solvent vapors, beryllium and ionizing radiation . . ."

On page 5 of this same report, the existing organization of the Health Department is charted, with eight divisions reporting to the Health Commissioner:

Bureau of Administration, Bureau of Public Health Nursing, Bureau of Health Centers, Bureau of Medical Services, Bureau of Food and Sanitary Inspection, Bureau of Laboratories, Bureau of Meat and Dairy Inspection, and the Bureau of Vital Statistics.

Health Centers and Health Stations

The following centers and stations were in existence in the 1950's offering diagnosis and treatment to the low income sick, diagnosis and referral to private physicians, and assisting private physicians in performing certain diagnostic tests and others, and relaying services:

Health Centers

Twelfth Street Health Center
Shoemaker Health Center
Madisonville Health Center

Health Stations

Bethel Health Station
Winton Terrace Health Station
English Woods Health Station
Cutter Health Station
Findlay Health Station
Christ Church Health Station
Woodward Health Station
Oyler School Health Station

1950 — 1960 Conquest of Poliomyelitis

Glancing through these reports from 1950 through 1960, the headings of some of the paragraphs reveal the current interests of the department: inspections, permit revocations, dishwashing quality, water control, lead poisoning, boarding homes, rat control, laboratory examinations, law enforcement, vital statistics, microfilming, sources of funds, the passing of Mr. Sol. H. Freiberg, a beloved and respected member of the Board on September 1, 1964 (first appointed in 1924), alcoholism, health education, industrial health, school nursing, communicable dis-

*Dr. Macleod, Cincinnati, is Commissioner of Health, City of Cincinnati.

Submitted March 16, 1966.

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eases, house visits, tuberculosis decline, venereal diseases, the Max Stern Heart Station, yellow fever vaccination, rabies control, meat inspection, and so on.

Poliomyelitis

A five-year comparison of poliomyelitis (1950-1954) indicated that the disease was a constant and ever-present danger during the late summer.

	City <i>Resident Cases</i>	Hamilton Co. <i>Cases</i>	Hamilton Co. <i>Cases (out of county)</i>	TOTAL
1954	110.....	74.....	77.....	261
1953	99.....	28.....	20.....	147
1952	129.....	55.....	32.....	216
1951	83.....	30.....	41.....	154
1950	63.....	33.....	45.....	141

(But Salk and Sabin were going to change all this within the decade — God bless 'em! K. I. E. M.)

Health and Well-Being

The philosophy of the World Health Organization as expressed in its definition of health as a state of complete physical, mental, and social well-being, not merely the absence of disease or infirmity, is noted in the report for 1954. Undoubtedly in Cincinnati, as elsewhere that philosophy was taking hold.

1955 Salk Vaccine

Under the heading "Progress — 1955" the following most significant paragraph appeared:

In one of the greatest mass immunization programs ever attempted, 34,262 first and second Salk poliomyelitis immunizations were given to Cincinnati school children. A great amount of credit is due to City Council for rushing through a special ordinance appropriating \$5,000 for the purchase of syringes, needles, and sterilizing equipment needed to conduct the program.

The William Muhlberg Health Center was dedicated that same year in June.

Cancer Control

Dr. Wilzbach received the national award for outstanding contributions to the control of cancer.

Crippled children, as required by the law, were visited routinely by the public health nurses. In 1955 some 1,865 children were visited.

Poliomyelitis

As to progress in the fight against poliomyelitis the figures for 1955 through 1960 are as follows:

	City Cases	County Cases	Out-of-County Cases	TOTAL
1960	3.....	?.....	?.....	3
1959	38.....	?.....	?.....	38
1958	28.....	?.....	?.....	28
1957	10.....	?.....	?.....	10
1956	28.....	6.....	4.....	38
1955	75.....	38.....	28.....	141

Venereal Disease Survey

A venereal disease survey conducted in 1955 revealed many new cases, out of a total of 10,953 people surveyed by serologic testing methods.

In 1956 two members of the Health Board died: Edward J. McGrath, M. D., and John M. Cronin, as noted in the 1957 annual report. Dr. Henry Clay Beekley, having taken up residence in the county, had to resign as a member of the Board. In their places, Dr. S. A. Schmid, Dr. Clare R. Rittershofer, and Mr. Tom T. Oyler were appointed. Dr. Schmid was appointed President later, and Mrs. Edward Kuhn, Vice-President.

Foodhandlers

The outstanding activity for 1956 was the initial mass x-ray of foodhandlers in Food Service Operations — a cooperative effort with the Anti-Tuberculosis League.

Asian Flu

It was noted in the 1957 Annual Report that For the first time in medical history, an epidemic was predicted and the nation was prepared for it and had a protective vaccine for it before it struck. This was the case with the Asian influenza attack during the year 1957.

In 1957 a public health nutritionist was hired for the first time.

In 1957 the use of shoe-fitting x-ray machines was banned in Cincinnati.

Staph Hits Hard

A staphylococcus of virulent and resistant nature continued to be troublesome during the year, being carried over from 1956. In hospitals it involved the maternity wards, newborn nurseries, and surgical wards particularly. Some hospitals appointed special committees to set up safeguards against the spread of the infection.

T. B. Control

A pilot study was conducted at Stowe School in an effort to find a new approach to finding tuberculosis cases in a high census tract area for tuberculosis. Tuberculosis testing of children came under a joint program of the Anti-Tuberculosis League, the Board of Education, and the Health Department. One case of active tuberculosis requiring hospitalization was discovered. Many others were found to show a positive tuberculin reaction and these were followed up . . .

Leading Causes of Death

The seven leading causes of death (1957-1953) were noted as follows:

	1957	1953
Heart	2,229	2,214
Cancer	964	872
Intracranial lesions....	614	710
Accidents	244	247
Pneumonia	221	196
Arteriosclerosis	216	245
Diabetes	148	134

Radiation Accidents

In his report for 1959, Dr. Wilzbach notes that The Cincinnati Board of Health has had experience in dealing with radiation accidents; the most notable incident occurring in 1952 when a radium capsule used for testing equipment being manufactured was broken and some 220



She simply sits while the party goes on around her, already used to being the girl who is left out. She tries to lose weight—but her emotions won't let her. She becomes irritable and depressed when she doesn't eat, and anxious when she considers her future. So each time she gives up.

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"How can I ever stay on a diet and lose weight?"*

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employees had to be examined as a result. Fortunately, no serious side effects resulted from this accident.

But in July of 1957 the Board of Health appointed a citizen's Radiation Advisory Committee.

1959

In his "Highlights for 1959" Dr. Wilzbach rates these: the changing of the Compulsory Rabies Vaccination Ordinance to permit the use of chick-embryo vaccine which confers immunity to dogs against rabies for three years; emergency procedures to be followed when any radioactive materials are present at any disaster; compliance with the new state law which requires that all children be immunized against polio, smallpox, diphtheria, tetanus and whooping cough; the formation of a committee to study lead poisoning because of dramatic increase in lead poisoning cases (68 in 1959) as compared with an average of 10 to 12 per year for the past several years.

Dr. Wilzbach retired in 1960, and was succeeded during that year by Dr. R. Eugene Wehr as "acting" Health Commissioner.

Dr. R. E. Wehr: Acting Health Commissioner, 1960 — The Sabin Vaccine

The outstanding and most significant event during 1960 undoubtedly was the city's participation in a program to eradicate poliomyelitis using the Sabin oral vaccine.

During two separate one-week periods, an estimated 76.7 per cent of all children ages three months through high school in the city, were fed Type 1 Sabin Oral Vaccine. Type 3 was given in November, 1960 and Type 2 in January, 1961.

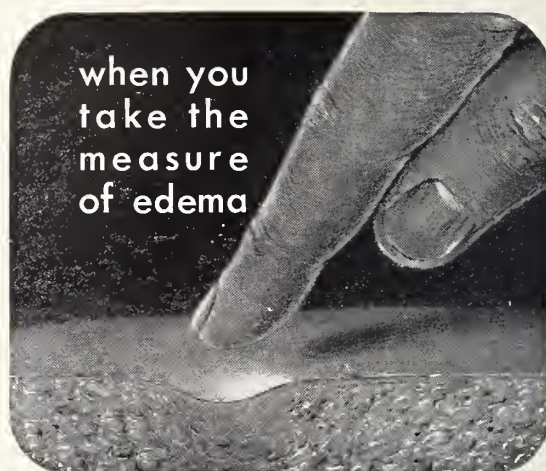
It is noted that during 1960 There were no clinically diagnosed cases of poliomyelitis reported in Cincinnati or Hamilton County, with the exception of one imported case of a 25 year old man who had never had Salk or Sabin vaccine.

During 1960 it was necessary to forcibly detain 25 persons who were affected with a communicable disease (venereal disease) and refused to submit to medical treatment. Detained because of tuberculosis were 47 persons — 38 were held at Municipal Isolation Hospital at the City Workhouse and nine at Dunham Hospital.

Dr. K. I. E. Macleod — 1961

On January 31, 1961 the author of this paper, Dr. Kenneth I. E. Macleod, succeeded Dr. Wehr as City Health Commissioner.

The Sixth Annual Michigan Kidney Foundation Symposium will be held at The University of Michigan Medical Center, June 3 and 4, 1967. Topics covered will be glomerular nephritis, urinary tract infection, dialysis, and transplantation. A detailed program of the Symposium and an application to enroll may be obtained from: Harry A. Towsley, M.D., Department of Postgraduate Medicine, University Hospital, Ann Arbor, Michigan 48104.



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DIURETIC ACTION: Clinically, the oral administration of AQUATAG (benzthiazide) results in diuretic activity within two hours with maximal natriuretic, chloruretic, and diuretic effects occurring during the fourth, fifth and sixth hours. Maintenance of response continues for approximately 12 to 18 hours. Acidosis is an unlikely complication since therapeutic doses of AQUATAG (benzthiazide) do not appreciably increase bicarbonate excretion. Edematous patients receiving 50 mg. of AQUATAG (benzthiazide) daily for five days developed a maximal increase in the rate of sodium excretion on the first day, and maintained this high rate until depletion of excessive body stores of sodium.

In congestive heart-failure patients, AQUATAG (benzthiazide) produced the same weight loss, during a 48-hour treatment period as did a maximally effective dose of hydrochlorothiazide.

DOSSAGE: Diuresis, initially 50 to 200 mg.; maintenance 25 to 150 mg., daily. Hypertension 50 to 100 mg. initially, adjusted to 50 mg. t.i.d. or downward to minimal effective dosage level.

WARNINGS: Use with caution in the presence of renal disease as azotemia may be precipitated or increased. In patients with advanced hepatic disease, electrolyte imbalance may result in hepatic coma. Dosage of coadministered antihypertensive agents should be reduced by at least 50%. In cases of suspected electrolyte imbalance, serum electrolyte determinations should be performed and imbalance, if any, corrected. Stenosis or ulcer of small intestine have been reported with coated potassium formulas, and surgery has been required and deaths have occurred. Based on surveys of both United States and foreign physicians, incidence of these lesions is low and a causal relationship in man has not been definitely established. Until further experience has been obtained, the use of the drug in pregnant patients should be weighed against possible hazards to the fetus.

CONTRAINDICATIONS: AQUATAG (benzthiazide) is contraindicated in progressive renal disease or dysfunction including increasing oliguria and azotemia. Continued administration of this drug is contraindicated in patients who show no response to its diuretic or antihypertensive properties. Severe hepatic disease is a relative contraindication. (See "Warnings" above.)

PRECAUTIONS AND SIDE EFFECTS: Electrolyte imbalance with hypokalemia (digitalis toxicity may be precipitated), hypochloremic alkalosis and hyponatremia may occur. Patients with cirrhosis should be observed for impending hepatic coma and hypokalemia. Other reactions may include blood dyscrasias, hyperuricemia and gout, nausea, jaundice, anorexia, vomiting, diarrhea, dizziness, paresthesia, photosensitivity and headache. Hepatic fetor, tremor, confusion and drowsiness are signs of impending pre coma and coma in patients with cirrhosis. Insulin requirements may be altered in diabetes. AQUATAG (benzthiazide) should be used with caution post-operatively as hypokalemia is not uncommon. Potassium supplementation may be advisable pre- and post-operatively. There have been occasional reports of thrombocytopenia, leukopenia, agranulocytosis, aplastic anemia and precipitation of acute pancreatitis or jaundice.

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Letter To The Editor

March 21, 1967

The Editor
The Ohio State Medical Journal
17 S. High Street, Suite 500
Columbus, Ohio 43215

Dear Sir:

I wish to extend work previously carried out in Western Australia¹⁻⁴ and in other parts of the world⁵ concerning the association of a Tj^a-like hemolysin with pregnancy in habitually aborting women and with infertility.

For the purposes of this project, I require serum from two classes of patients:

1. Women with a history of habitual abortion who have never been delivered of a live, full-term infant and who are considered to have become pregnant.

2. Women currently under treatment for infertility at the time when conception is being attempted and preferably several days before their due menstrual period, or later, in the event that it should be delayed.

Ten milliliters of whole blood collected without anticoagulant and accompanied by a brief clinical note should be forwarded to me at the address given below. There is some evidence that the presence of the hemolysin may be a factor directly associated with abortion in both clinical groups and that the serological findings may have valuable prognostic significance. Cooperation on the part of medical practitioners in the State will be gratefully appreciated.

References

1. Wren, B. G., and Vos, G. H.: *J. Obstet. and Gynaec. Brit. Comm.*, 68:637 (1961).
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3. Vos, G. H.: *Transfusion*, 5:327 (1965).
4. Vos, G. H.: *Transfusion*, 7:40 (1967).
5. Horvath, E., and Paisz, I.: *Transfusion* 6:499 (1966).

JAMES G. NORMAN, M. D.
Asst. Professor of Clinical Pathology
and Director of the Blood Bank
West Virginia University Medical
Center
Morgantown, West Virginia 26506

The Southwestern Ohio Society of Family Physicians presented a seminar on "Vascular Disease Amenable to Surgery," in collaboration with the University of Cincinnati College of Medicine on March 5.

Patients in Ohio State University Hospitals are receiving copies of an enlarged paper match folder containing the title "Safety Tips." Inside is a list of safety suggestions which patients are urged to follow.

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*As shown by *in vitro* studies.

1. Crunden, A. B., Jr., and Davis, W. A.: Am. J. Obst. & Gynec. 65:311 (Feb.) 1953.

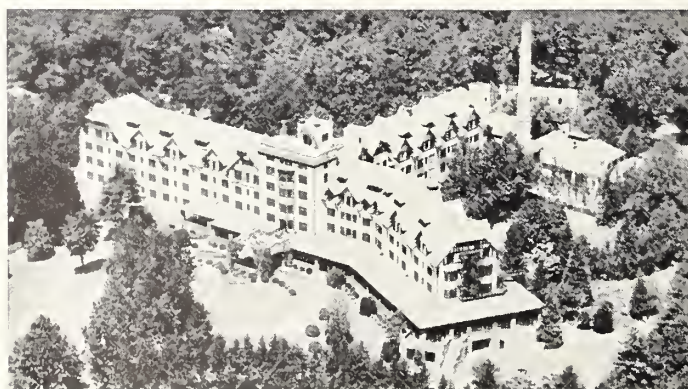


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New Members of the Association . . .

Following are names of new members of the Ohio State Medical Association certified to the headquarters office during March. List shows name of physician, county, and city in which he is practicing, or in which he is taking postgraduate work.

Allen
Jong S. Park, Lima

Ashland
Jon H. Cooperrider,
Loudonville

Athens
George L. Lemon, Athens

Brown
Robert Alan Baker,
Georgetown
Robert S. Benintendi,
Georgetown

Butler
Ivan T. Lindgren, Oxford
Orhan A. Tugrul, Hamilton

Clark
Walter R. Lawrence,
Springfield
William R. Kendall,
Washington, C. H.

Columbiana
Allan A. O'Brien,
East Liverpool
H. David Evans, Salem
Rheinhold Rankis, Lisbon

Cuyahoga
George R. Andraso, Cleveland
Shawki S. Asmar, Cleveland
Mehmet F. Bayri, Cleveland
Glenn P. Beck, Cleveland
Edward S. Bush, Cleveland
Edward R. Cerutti, Cleveland
Eugene J. Chandler, Cleveland
Lawrence L. Cockerille, Jr.,
Cleveland
Roberta R. Coffin, Cleveland
Peter J. Cohn, Cleveland
Oscar K. Cosla, Berea
Arel R. Cunningham, Jr.,
Bedford
Morris W. Dickey, Cleveland
Victor H. Frankel, Cleveland
Manuel E. Gordillo,
Cleveland
Thomas E. Gretter, Cleveland
Harry B. Houser, Cleveland
Robert A. Ingram, Cleveland
Ramon Fernandez-Isales
Cleveland
Michael J. Kehoe
Cleveland
Hans Alfred Lindt, Cleveland
Stephen F. Luczek, Cleveland
John E. Maier, Cleveland
David L. Mallett, Cleveland
Richard B. Markey, Cleveland
Valentin F. Mersol, Cleveland
Anthony C. Nassif, Cleveland
Myrna P. Nugent, Cleveland
George R. Petric, Cleveland
Jerome R. Pomeranz,
Cleveland
Robert J. Porter, Cleveland
Angelo M. Ramacciato,
Cleveland
Joel S. Rankin, Cleveland
Henry H. Roenigk, Jr.,
Cleveland
Fayiz A. Salwan, Cleveland
Kyung W. Shin, Cleveland
John A. Stanley, Cleveland
Zenobius Staszko, Cleveland
Marian Z. Tomaszewski,
Cleveland
Gerald E. Weinberg,
Cleveland
Alan H. Wilde, Cleveland
George F. Wright, Cleveland
Frederick J. Ziegler, Cleveland

Franklin
Jerold H. Altman,
Worthington
Nobuhisa Baba, Columbus
Philip J. Bernard,
Reynoldsburg
Delbert L. Brown,
Worthington
Harold V. Ellingson,
Columbus
Clarence R. McLain, Jr.,
Columbus
Tearle L. Meyer, Columbus
George H. Miller, Columbus
Joseph V. Scrivani,
Worthington
Irving Seidemann, Columbus
Richard E. Simmons
Columbus
John C. Stockdale,
Worthington
Neil R. Thomford, Columbus

Gallia
Marcel Q. Coronel,
Gallipolis

Greene
Dale C. Metheny,
Yellow Springs

Guernsey
Quentin F. Knauer,
Cambridge

Hamilton
Daniel L. Friedberg,
Cincinnati
O. Redmond McNeill,
Cincinnati
Manuel H. Mediodia, Jr.,
Cincinnati
Donald A. Shumrick,
Cincinnati
Jane Markarian Shutt,
Cincinnati
Richard G. Wendel, ^{Ch}
Cincinnati

Hardin
Silvio R. Jova, Kenton

Lake
Roy E. Ronke, Jr.,
Willoughby

Lawrence
William Lee Haskins, Ironton

Licking
Lawrence A. Dils, Granville
John R. Pollock, Newark

Lorain
Sami A. Sfeir, Lorain

Lucas
Richard C. Ashcom, Toledo
Benjamin W. Butler, Toledo
Charles H. Harrison, Toledo
Frederick L. Hotchkiss,
Toledo
John J. McHugh, Toledo
Sonja S. Pinky, Toledo
Angel M. Quinto, Toledo
Ladislao K. Wallerstein,
Toledo
Joseph K. Welborn, Toledo

Mahoning
Rashed A. Abdu,
Youngstown
John B. Werning,
Youngstown

Marion
Ross P. McConnell, Marion

Montgomery
Alfred J. Magnotta, Dayton
Heather J. Morgan, Dayton

Muskingum
Juan R. LaCerdá,
Zanesville

Portage
Rodolfo A. Arner, Ravenna
F. Michael Sheehan, Ravenna

Richland
Robert E. Barkett, Mansfield
Cecil R. Burkhart, Mansfield

Summit
Guillermo Alfonso, Akron
Alan W. Holderness, Akron

Trumbull
H. Richard Hunt, Warren
Alan R. Kightlinger, Warren
James LaPolla, Warren
Ferruh Unalan, Warren

Tuscarawas
Brian S. Harrold, Canton

Washington
Tom D. Halliday, Marietta

Wayne
Herbert E. Allshouse,
Wooster

American Heart Association Sets Up Stroke Council

A Council on Cerebrovascular Disease has been established by the American Heart Association. In making the announcement, Dr. Lewis E. January, AHA President, pointed out that stroke always has been a prime concern of the Heart Association, although heretofore no formal council covered the area.

The new council is an outgrowth of the AHA's Coordinating Committee for Nationwide Stroke Program and will initiate and coordinate national and local programs of research, graduate and undergraduate medical education, all allied professional education, public education and information, and community services in the area of stroke.

Serving as the council's Chairman is Dr. Clark H. Millikan of the Mayo Clinic, Rochester, Minn. Vice Chairman is Dr. John W. Goldschmidt of Jefferson Medical College and Hospital, Philadelphia.

The Stroke council brings to nine the number of scientific councils functioning within the AHA as professional societies concerned with subspecialty areas in the cardiovascular field. The other eight councils are concerned with arteriosclerosis, basic science, cardiovascular surgery, circulation and renal diseases, clinical cardiology, epidemiology, high blood pressure research, and rheumatic fever and congenital heart disease.

Toxic Little Brown Spider Expanding Its Haunts

The American Medical Association in a general news release reports that the Brown Recluse (*Loxosceles reclusa*), described as a brown spider with a bite probably more toxic than that of the Black Widow, is expanding its territory.

Although no mention was made of experience in Ohio, the spiders have been reported in the Southern United States from the Carolinas to Colorado, and as far north as Missouri and southern Illinois.

Worldwide clinical experience confirms the predictable therapeutic potential of Synalar

It is particularly gratifying that the promise of the advanced chemical design and high order of bioassay activity of Synalar (fluocinolone acetonide) has been confirmed by widespread therapeutic application. Indeed, the impressive clinical response rate of Synalar has been documented in no fewer than 232 papers from 22 countries.

PRESCRIBING INFORMATION

For initiation of therapy: Cream 0.025%, 5 and 15 Gm. tubes, 425 Gm. jars; *for emollient effect:* Ointment 0.025%, 15 Gm. tubes; *for maintenance therapy:* Cream 0.01%, 15 and 45 Gm. tubes, 120 Gm. jars; *for intertriginous or hairy sites:* Solution 0.01%, 20 cc. and 60 cc. plastic squeeze bottles; *for infected inflammatory dermatoses:* Neo-Synalar® Cream (0.025% fluocinolone acetonide, neomycin sulfate, equivalent to 0.35% neomycin base), 5 and 15 Gm. tubes.

CONTRAINDICATIONS: Tuberculous, fungal, and most viral lesions of the skin, (including herpes simplex, vaccinia, and varicella). Not for ophthalmic use. Contraindicated in individuals with a history of hypersensitivity to any of the components. **PRECAUTIONS:** Synalar preparations are virtually nonsensitizing and nonirritating. However, the solution may produce burning or stinging when applied to denuded or fissured areas. In some patients with dry lesions, the solution may increase dryness, scaling or itching. While topical steroids have not been reported to have an adverse effect on pregnancy, the safety of their use on pregnant females has not absolutely been established. Therefore, they should not be used extensively on pregnant patients, in large amounts, or for pro-

Representative Clinical Results with Synalar*

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Condition	Number of Publications	Number of Patients	Significant Improvement†
Contact Dermatitis	27	750	713
Eczematous Dermatitis	21	472	409
Seborrheic Dermatitis	18	442	426
Atopic Dermatitis	24	460	426
Psoriasis	36	1,699	1,510
Neurodermatitis	18	351	324
Total	144	4,174	3,808

*Complete bibliography on request.

†Expressed by the authors as excellent, very good, good, complete remission of inflammation, etc.

longed periods of time. Prolonged use of any antibiotic may result in overgrowth of nonsusceptible organisms; if this occurs, appropriate therapy should be instituted. When severe local infection or systemic infection exists, the use of systemic antibiotics should be considered, based on susceptibility testing. **SIDE EFFECTS:** Side effects are not ordinarily encountered with topically applied corticosteroids. As with all drugs, however, a few patients may react unfavorably to Synalar under certain conditions. The neomycin in Neo-Synalar Cream rarely produces allergic reactions.

REFERENCES: 1. Lerner, L. J., Bianchi, A., Turkheimer, A. R., Singer, F. M., and Borman, A.: Anti-inflammatory steroids: potency, duration and modification of activities. *Ann NY Acad Sci* 116:1071 (Aug. 27) 1964. 2. Idem: Comparison of anti-granuloma, thymolytic and glucocorticoid activities of anti-inflammatory steroids. *Proc Soc Exp Biol Med* 116:385 (June) 1964. 3. Ringler, A.: Activities of adrenocorticosteroids in experimental animals and man, in Dorfman, R. I.: *Methods of hormone research*, New York, Academic Press, 1964. vol. III. pp. 234-280. 4. Gubersky, V. R.: To be published.

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Ohio State University Medical Alumni Special Awards Presented to Four Physicians at Reunion

THREE alumni achievement awards and one merit award, based on meritorious service and contributions to medicine, school and community, were presented at the 14th Annual Medical Alumni Reunion of the Ohio State University on April 22.

Physicians selected to receive alumni achievement awards were Dr. Robert Francis Dickey, Miami, Florida; Dr. Miner Seymour, Columbus; and Dr. Robert Young, Johnstown.

Selected to receive the merit award, was Dr. Perry R. Ayres, Columbus, Editor of *The Ohio State Medical Journal*.

The Annual Medical Alumni Reunion was held in the Ohio Union on the campus. The Alpha Omega Alpha breakfast initiated the day's activities, preceding an informal program of exhibits and demonstrations by students and faculty members for all alumni. Color slide presentations showed changes in educational programs, research, faculty, and physical expansion.

Highlights of the program included presentation of 50-year certificates to class members of 1917. Special recognition was given to the five year classes from 1917 to the present. Dr. Grant O. Graves, Columbus, presided as alumni president, and Dr. Clement F. St. John, Cincinnati, assumed office as the 1967-1968 president.

Following are brief sketches of the four physicians who received special honors.

Dr. Robert Dickey, class of 1937, is a clinical assistant professor of surgery at the University of Miami (Florida) School of Medicine, and was director of Surgical Services at the Variety Children's Hospital in Miami until 1965.

He is medical director of Doctor-to-Doctor International, a nonprofit nonremunerative association of practicing dentists and physicians that was founded in Miami in 1960. Members offer their services at lectures, clinics, and consultations, or in procurement of drugs, instruments, etc., for the benefit of other physicians and dentists. They have visited Colombia, San Jose, Costa Rica, Honduras, Nicaragua, and Ecuador, as well as Coral Gables in Florida, and this year will tour in Bogota and Manizales, Colombia.

Dr. Dickey is a fellow of the American College of Surgeons, and has active or honorary membership in numerous other professional organizations.

Dr. Miner Seymour, class of 1937, has been a faculty member in the department of pediatrics at Ohio State since 1940 and currently holds the rank of clinical professor. Since his days as chief resident at Children's Hospital in Columbus, he has served on



Dr. Dickey



Dr. Seymour



Dr. Young



Dr. Ayres

the hospital executive committee and has twice been chairman of the staff. He has been a member of the pediatrics teaching committee since its inception.

Dr. Seymour has been in private practice in Columbus except for a period during World War II when he was in the Army Medical Corps. In military service, he advanced from the rank of first lieutenant to full colonel, serving as executive officer and then as commander in charge of the 155th General Hospital in England.

Dr. Robert Young, class of 1947, has been in general practice in Johnstown since 1948. A past president of the Central Ohio Academy of General Practice, he was also a founder of the Annual Family Practice Review Seminar held at St. Anthony's Hospital in Columbus. He has been the speaker for three consecutive years at the Annual Medical Student Banquet, planned to foster student interest in general practice. He is presently delegate to the OAGP House of Delegates and is chairman of the statewide nominating committee of the Ohio Academy of General Practice.

Dr. Young is a past chairman of the Department of General Practice at Riverside Methodist Hospital, Columbus, and as a member of the constitution com-

(Continued on Page 616)



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mittee, helped to establish that department at Riverside and to provide two accredited residencies in the same field.

During the Korean War, Dr. Young was a captain in the Medical Corps with the Prisoner of War Command in Korea and received an Army commendation ribbon for his activities relating to the formation of community health centers in South Korea.

Active in civic affairs also, he is a past president of the Johnstown PTA and Johnstown Boosters, a founder of Johnstown Enterprises, and is presently the team physician for the Johnstown Monroe School.

Dr. Perry R. Ayres is a clinical associate professor and a member of the faculty at Ohio State since 1950. His major OSU activities at the present are in the Cardiology Clinic and in the preceptorship program in the course on "Behavioral Sciences" for first year medical students.

Dr. Ayres received his medical degree from Western Reserve University in 1942 and was an intern at Syracuse University Medical Center. For the next three years he was a lieutenant with the 4th Marine Division at Roi-Namur, Saipan, Tinian, and Iwo Jima, winning the Bronze Star. Returning to Cleveland in 1946, he served residencies in pathology and internal medicine from 1946-50.

Dr. Ayres has been practicing internal medicine and cardiology in Columbus since 1950 and was certified by the American Board of Internal Medicine in 1951. He is a fellow in the American College of Physicians.

He was editor of the *Bulletin* of the Columbus Academy of Medicine for several years and is now editor of *The Ohio State Medical Journal*, having accepted this post in 1959. He has served as president of the Columbus Metropolitan Health Council, as a director of Ohio Medical Indemnity, and as vice president of the United Community Council. He is currently secretary of the State Medical Journal Advertising Bureau, and a member of its Board of Directors.

JAMA Is Now Publishing Column On Medicine and Religion

A new section on medicine and religion has been started by *The Journal of the American Medical Association*, the first column being in the April 10 issue. First topic for discussion was organ transplantation.

Discussions are based primarily on inquiries from physicians.

The AMA established a Committee on Medicine and Religion in 1963, under direction of the Rev. Paul B. McCleave. The AMA reported that since then committees have been set up in medical associations in every state. Ohio was one of the first states to establish such a committee.

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Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently.

Warning: If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with great caution in the first trimester of pregnancy.

Precautions: Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should be closely supervised and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools or other evidence of intestinal hemorrhage. Make regular blood counts. Discontinue the drug and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The most common are nausea, edema and drug rash. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. Infrequently, agranulocytosis, or a generalized allergic reaction may occur and require withdrawal of medication. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

Dosage in Painful Shoulder: 600 mg. daily in divided doses for 2 to 3 days; 300 mg. daily thereafter. Usual duration of therapy: 2 to 7 days.

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Scientific Section

Vol. 63

MAY, 1967

No. 5

Bronchogenic Carcinoma Its Present-Day Management

NORMAN H. BAKER, M. D., and H. GENE EWY, M. D.

THE FIRST successful pneumonectomy for bronchogenic carcinoma was accomplished in 1933 by the late Dr. Evarts Graham, of St. Louis. It is extremely interesting and contrary to the usual case, in that this patient was a physician. After a preliminary bronchoscopy, and biopsy of the lesion, Dr. Graham explained the gravity of the situation in the proposed treatment. His patient was apparently quite undisturbed. He agreed with the plan of treatment, but said he would like to go home for a few days to tend to some business. Following this, he would be back for surgery. Dr. Graham found out two things that the patient did while home. The first was encouraging. He went to his dentist, and had some teeth filled. The second was perhaps more practical. After getting his teeth filled, he went to the mortuary and bought a cemetery lot. Dr. Graham has since died with carcinoma of the lung; his was inoperable. His patient, the physician from Pittsburgh, lived a long and fruitful life, dying some years after Dr. Graham.

Over the past three and one-half decades many modalities of treatment have been used for patients with carcinoma of the lung, e.g., pre- and post-operative roentgen therapy, systemic chemotherapy, and localized perfusion of the lung with chemotherapeutic drugs. It is the purpose of this paper to clarify the management of the primary as well as the secondary problems associated with bronchogenic carcinoma.

Diagnosis

As thoracic surgeons, we are usually the second, third, or fourth physicians to see these patients. It is interesting, in reviewing our files, to note the varied

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presenting symptoms. Approximately 90 per cent of our patients come to the office with an x-ray film demonstrating a lesion in the lung. This may have been noted anywhere from two weeks to 16 months prior to their visit. Seven per cent of the patients presented with a slowly resolving pneumonia, and the remaining with varied symptoms such as hemoptysis, systemic manifestations, or infectious complications of an obstructed bronchus. Two patients in this group had a normal chest x-ray. The presenting symptom to their referring physician was hemoptysis in one and a unilateral wheeze in the other.

If the lesion is central, or if there is any evidence of hilar enlargement, a pre-scalene node dissection is done whether or not nodes are palpable. Unlike the work of Rouviere, we have found the lymphatic drainage of the lower lobes to be predominantly ipsilateral to the appropriate pre-scalene nodes. Bronchography is reserved for the peripheral lesion which is beyond the limits of the bronchoscope and when cytology studies are nonproductive. All pa-

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tients had pulmonary function studies prior to surgery. Mediastinoscopy is reserved for patients with bilateral hilar involvement, and in patients who may not be candidates for a thoracotomy when a diagnosis has not been obtained by the usual methods.

Malignant pleural effusion is not uncommon and this is tapped immediately upon hospitalization. If the fluid contains malignant cells, the patient is considered unresectable. A solution of nitrogen mustard is instilled into the pleural space prior to dismissal from the hospital. We have found that approximately 50 per cent of patients will need no further treatment for their pleural effusion. If this does return, then repeated thoracenteses and/or tube drainage are often necessary. We have several patients with a malignant effusion from a very slow growing breast carcinoma, who were treated quite satisfactorily by parietal pleurectomy.

Treatment

After these preliminary studies, 50 per cent of our patients were candidates for resection. Blood volume studies were done and appropriate consultations for cardiac, renal, and other significant complicating diseases were obtained. Some years ago, preoperative roentgen therapy appeared promising, but subsequent reports have cast considerable doubt on the value of this treatment. There is one situation in which preoperative roentgen therapy is of value, and this is the patient with a superior sulcus tumor.

Pneumonectomy versus lobectomy, with or without a radical mediastinal node dissection continues to be a controversial subject. If a pulmonary neoplasm was drained by the pulmonary lymphatics alone, the controversy would be akin to a quiet fireside chat. However, it is well documented that up to 80 per cent of operative specimens will show microscopic and intravascular evidence of vascular invasion. With this fact in mind, the staggering statistics on each side continue to be very difficult to evaluate.

It is apparent to us that a surgeon cannot stand solidly with one camp or the other and treat each patient as an individual. Our primary purpose is to remove all of the carcinoma that is present in the chest. If a lobectomy and radical node dissection can do this, then it is the procedure of choice. If the patient with a reasonably good pulmonary reserve requires an intrapericardial resection and radical node dissection, then this is the primary procedure. Many of our patients are in the older age group and have severe obstructive airway disease. It is in these patients where a lobectomy with a radical node dissection has given excellent results. Additional procedures such as bronchoplasty, chest wall, diaphragmatic, pericardial or partial auricular resection when it is necessary, should be done when applicable to that patient.

Fifteen per cent of our cases were unresectable. This is a distressing and emotionally laden group of cases. Treatment of the patient begins with a sincere

interest in his problem and complete honesty with everyone involved. The families will often grasp for the shortest straw and should be guided by mature and honest advice. We have never removed the last ray of hope from our patients. They are all told of their problem and what we might do if we were in such a state. Very often, this is all that is necessary.

When a patient has pain, hemoptysis or a chronic cough from the neoplasm, they are candidates for palliative roentgen therapy. If edema from superior vena cava obstruction is noted, nitrogen mustard or radiation will be of some value. This is particularly true of patients with anaplastic carcinomas. If none of the above symptoms is present and there is no evidence of metastatic spread, they are seen in consultation by a radiologist. When evidence of extrathoracic disease is present, then a chemotherapeutic agent may be given on a palliative schedule. Unfortunately, chemotherapy has not proven to alter the course of patients with unresectable or metastatic bronchogenic carcinoma.

Discussion

It would be remiss to discuss the treatment of bronchogenic carcinoma without alluding to the danger of smoking. It has been proven, to our satisfaction, that cigarette smoking has a specific cancerogenic effect on bronchial mucosa and does produce bronchogenic carcinoma. It is also apparent that this is not the only cause, and that immune mechanisms, genetics, et cetera must play a role in the specific individual involved. The one factor that can be controlled, at the present time, is cigarette smoking. Millions of people and some of our children will be lost unless the medical profession takes a firm stand on this subject. It is our moral responsibility to warn, at least the younger generation, of the significant health hazard that cigarette smoking presents.

There are several ways that the survival of patients with bronchogenic carcinoma can be improved. The first is to further encourage our patients to have yearly chest x-rays. The resectability rate of isolated pulmonary nodules approaches 90 per cent. The five year survival is quadrupled in this group. The ordinary patient who comes into the office has only a 50 per cent chance of being resectable.

The second is to remove the asymptomatic nodule that does not show concentric calcification on lamino-graphy. It has been shown that 10 per cent of malignant nodules contain calcification when the specimen is x-rayed. The presence of calcification other than that mentioned should not deter removal.

Third, the treatment of bronchogenic carcinoma, when operable, is removal of the lesion. Lobectomy and mediastinal node dissection is the operation of choice. Other modalities of surgical treatment are used depending upon the local situation and the physiologic status of the patient.

Kaposi's Sarcoma in the American Negro

Case Report and Discussion

DOUGLAS P. FUSONIE, M.D., and THOMAS H. BREWER, M.D.

THERE have been many cases of Kaposi's sarcoma described in the literature since Kaposi's original report. A preponderance of occurrences among certain groups of people has been reported and a genetic and regional predisposition to the development of the tumor has been implied. However, for whatever the reason, there have been very few reported instances of Kaposi's sarcoma in the American Negro. Recently, we were confronted with just such a tumor in a Negro man, the diagnosis being made with some difficulty as shall be pointed out. We believe this case merits reporting, not only because of the scarcity of reported cases in the American Negro, but also because the sequence of diagnostic events would imply that the tumor may be more common among American Negroes than we were originally led to believe.

Case Report

A 54-year-old Negro man was admitted to St. Anthony Hospital, May 24, 1966, complaining of a "growth on the bottom of the right foot." The patient had noted a hard, raised mass on the plantar surface of his right foot ten days prior to admission. The mass was dark purple and tender to touch and caused him a great deal of pain when walking. Thinking that it was a "blood blister," the patient attempted to "lance" it. A small amount of serosanguineous drainage resulted and continued daily until admission.

The patient later recalled that one year prior to admission he was bothered for one week by a soreness in the same area. Although there was no elevated lesion then, it seemed there was a darker area of skin present.

At the time of admission, a 2 by 2 cm., pedunculated, purplish red, superficially ulcerated lesion was noted on the plantar surface of the right foot, in the proximal tarsal area. No further lesions were seen and there was no inguinal adenopathy. The rest of the physical examination was within normal limits. Laboratory studies were normal. An x-ray of the foot showed only a soft tissue swelling with no periosteal reaction or intrinsic bony lesions. Subsequent chest x-ray, EKG., and barium enema were normal.

A simple excision of the lesion with primary closure was carried out. The pathologist reported the tumor as "hemangioendothelial sarcoma" with a low degree of malignancy. The slides were reviewed also at Ohio State University Hospital where the possibility of Kaposi's sarcoma was raised. Subsequently, the slides were sent to the Armed Forces Institute of Pathology where the staff reported the lesion as Kaposi's sarcoma.

The patient has since returned to St. Anthony Hospital

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where a wide excision of the area and split thickness skin grafting were carried out.

Discussion

A. Incidence

Kaposi's sarcoma has been reviewed by many investigators and reported to occur rarely in the American Negro, while occurring most frequently in Eastern and Central European Jews and their descendants, and Northern Italians and their descendants.¹⁻⁴ While most extensive reports agree with this generally accepted incidence, there are a few surprising reports that seem to challenge old assumptions. In fact, Cox and Helwig reported on 50 cases, 11 of which occurred in Negroes, with 8 cases among Italians and no cases in Jews.⁵ Interestingly also, there have been reports in recent years of a heavy incidence of Kaposi's sarcoma in the Negroes of the Belgium Congo, South, and Southwest Africa.^{6,7} In fact, according to Dr. A. G. Oettle of the South African Institute and Cancer Research Unit, the tumor is 20 times more common among the Bantus than among the whites in the Transvaal area.⁸

B. Appearance and Course of the Disease

The tumor usually begins as a bluish-red to brown macular lesion, most frequently involving the lower extremities. The lesion usually becomes nodular or plaquelike and other lesions develop in a progression toward the trunk. It is interesting to note that in the Bantus of Africa, the lesion is most frequently found growing in an outward protruding manner rather than sideward as the well known macular and subsequently nodular manner in the white.⁹ Roth-

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man calls attention to Keen's, Basset's and Payet's observation that the macular lesion is seldom seen in the darker skinned African natives, although the sarcoma itself is darker than any other cutaneous lesion in the race.¹⁰

The course of the disease is progressive with development of new nodules, ulcerations, and lymphedema. Frank metastasis is rare, although sarcomatous degeneration with subsequent metastasis does occur. The tumor appears to be of multicentric origin and the gastrointestinal tract, spleen, liver, and marrow, etc., may be involved. In fact, these areas may be the sole site of the tumor with no evidence of skin involvement.¹¹

C. Histology

There is a great deal of variation in pattern and cell predominance histologically in Kaposi's sarcoma. Frequently there are only a few mitoses. As pointed out earlier, there may be a difference of opinion concerning the diagnosis. As an example of the histology and difference of interpretation, Figs. 1 and 2 from our own case are shown. It should be remembered that the diagnoses varied from hemangio-endothelial sarcoma of low grade malignancy to frank Kaposi's sarcoma.

In Fig. 1, the microscopic section is shown under

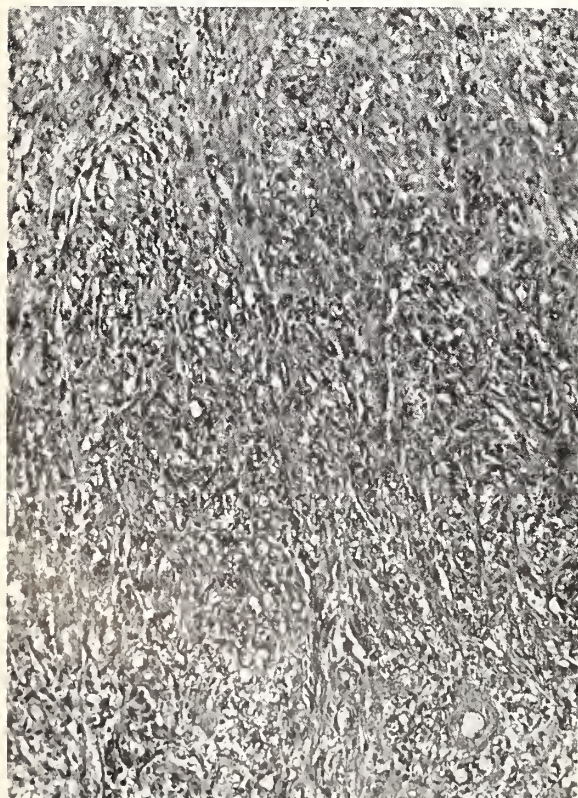


FIG. 1. Photomicrograph of low power view of H and E stained section of the Kaposi's sarcoma removed from the patient's foot. The collagen bundles are irregular and often spindle cell variety. Note the marked proliferation of capillary vessels replacing the usually dense collagen. (H and E stain)

low power. Normally dense collagenous bundles appear as spindle cells and are displaced or replaced by vascular channels.

In Fig. 2, a section is seen under high power. Both thin and thick-walled capillary vessels are seen interspersed in the tumor and showing prominent pericytes. In addition, some hemorrhage is seen, accompanied by inflammatory infiltrate, moderate anaplasia and mitoses. In Fig. 3, characteristic hemosiderin granules appear with iron stain.

There is a disagreement concerning whether the lesion is a true blood vessel tumor or a pericyte fibroblastic tumor. However, whatever the nature, the histologic pattern is quite variable, but, nevertheless, diagnostic. If one is thinking of the possibility of Kaposi's sarcoma, the diagnosis is that much easier to arrive at when reviewing the microscopic sections.

Conclusion

Kaposi's sarcoma has been reported only infrequently in the American Negro. The implication of accumulated reports and texts has been that there is a very low incidence among Negroes, while there is a much higher incidence among whites, particularly those whites of East Central European, Jewish, and Northern Italian origins. However, some recent reports would indicate that the incidence among Negroes may be much higher than previously suspected. Furthermore, the recently reported incidence of Kaposi's sarcoma in certain African native groups is actually higher than that in the white man. One should suspect, then, that the American Negro, related to some of the African groups, would have a higher incidence than commonly accepted. Some isolated reports indicate that this may be true. Why then is there such a low overall reported incidence of the tumor in the American Negro? The authors do not pretend to know the full answer. Perhaps the low reported incidence is real. On the other hand, perhaps it results from a low index of suspicion with subsequent faulty diagnosis. It is quite probable that the early macular lesion is not noted as frequently in the Negro due to skin color. It is also apparent, as in our case, that a mistaken pathologic diagnosis may be arrived at on viewing the microscopic sections.

Summary

Kaposi's sarcoma may occur more frequently than previously suspected in the American Negro. The reports we have cited suggest that previously held concepts may not be altogether true. Lack of suspicion, especially in relation to microscopic sections, can result in a failure to make this diagnosis. A case is reported in a Negro man in which Kaposi's sarcoma was not suspected and in which the initial reported microscopic diagnosis was faulty. What-

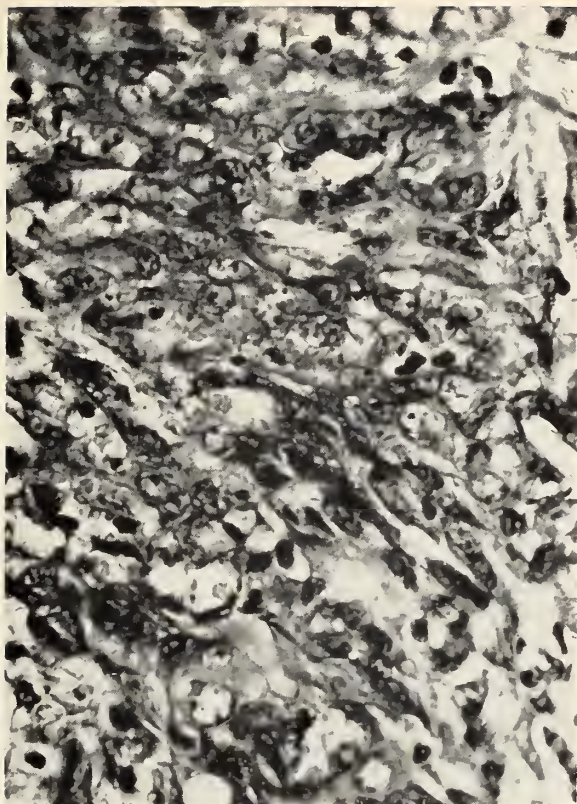


FIG. 2. Photomicrograph of the high power view of same section showing thick walled capillary vessels and newly formed thin walled capillaries. Note the prominent pericytes. Observe the inflammatory infiltrate, hemorrhage and degree of anaplasia and mitosis. (H and E stain)



FIG. 3. Photomicrograph of the tumor section under low power after the application of an iron stain. Characteristic hemosiderin granules are readily seen. (Iron stain)

ever the incidence, it behooves the clinician to be aware that Kaposi's sarcoma does occur in the American Negro and that careful microscopic examination should lead to the diagnosis.

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ANXIETY appears in many disguises and mimics most other afflictions. Once the anxious patient has been recognized as such and a proper diagnosis is made, management of him is easily carried out within the framework of the medical transaction.

Lack of awareness of underlying anxiety in a patient who presents with somatic complaints can lead to poor results for the patient and frustration for the physician. It is not the physician's role to remove all anxiety. Rather, it is his mission to manage the anxious patient so as to mediate the anxiety allowing for integrated adaptive function. — Werner M. Mendel, M.D., Los Angeles: *California Medicine*, 102:123-126, February 1965.

Abstracts from Regional Meeting of American College of Physicians

EDITOR'S NOTE: Again this year *The Journal* is pleased and proud to publish abstracts of the papers read at the Combined Regional Meeting of the American College of Physicians for Ohio, West Virginia, and Western Pennsylvania January 20-21, 1967, in Morgantown, West Virginia. The abstracts present in concise form a wealth of information reflecting the nature of current medical research in this part of the country. We are indebted to Dr. John E. Jones and his Program Committee for the selection of the papers and to them and Drs. Edmund B. Flink, Richard W. Vilter, and William M. Cooper, Governors of the College for West Virginia, Ohio, and Western Pennsylvania, respectively, for permission to publish the abstracts.

* * *

Gross Variation in the Glucose Tolerance Induced by Moderate Activity

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The reproducibility of the glucose tolerance test has been disappointing. The wide variation in glucose tolerance test results has limited the usefulness of the test and results in disagreement as to what is normal. Much attention has been given to the antecedent diet, some attention has recently been given to the state of potassium balance, but little concern has been apparent regarding the subject's wakefulness, restlessness, or amount of ambulation before and during the test. The effect of activity on the control of diabetes is widely recognized and studies of non-insulin mediated glucose utilization in severe exercise have been reported.

We have conducted a study to determine if mild exercise as would be usual in the ambulatory patient has an effect on the glucose tolerance test as compared with that of the bedridden patient. Eight ap-

parently healthy men, age 24 to 34, were given 100 grams of glucose orally in the post-absorptive state on two different mornings. They then either slept during the course of the six hour glucose tolerance test or walked at a rate of 2 miles per hour for six hours. The activity was limited to prevent symptomatic sympathetic response.

The mean results with standard errors were as shown in Table 1 on this page. Plasma free fatty acids were significantly lower throughout the last four hours of the walking test.

Similar changes were also demonstrated during the intravenous glucose tolerance test. Twenty-five grams of glucose were injected intravenously while five subjects slept and on another day while they walked at 2 miles per hour. The coefficient of glucose utilization mean and standard error were 0.86 ± 0.10 sleeping and 2.77 ± 0.37 walking ($p < 0.01$).

The state of activity during a glucose tolerance test is obviously of previously unappreciated importance in interpreting the test.

* * *

TABLE 1. (Drs. Paul Davidson and Margaret J. Albrink)

TIME	PLASMA GLUCOSE mgm. %			PLASMA INSULIN uU/ml		
	Walking	Sleeping	p	Walking	Sleeping	p
0 minutes	102±3	102±3	n. s.	25±3	26±3	n. s.
15	127±4	127±7	n. s.	63±9	58±8	n. s.
30	150±8	158±5	n. s.	83±16	102±13	n. s.
60	150±14	178±8	<0.1	78±16	106±29	n. s.
120	115±5	163±10	<0.002	61±11	109±13	<0.02
180	96±5	128±6	<0.001	32±6	79±10	<0.002
240	100±2	104±6	n. s.	26±4	45±10	<0.01
300	103±1	85±3	<0.001			
360	101±1	96±3	n. s.			
Total above baseline	4226±933	10633±1078	<0.001	7765±1684	13874±1672	<0.05

Serum Insulin, Carbohydrate, and Lipid Abnormalities in Patients with Premature Coronary Heart Disease

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A close association exists between atherosclerosis and diseases such as hyperlipidemia or diabetes mellitus. An abnormal serum insulin response after glucose is often observed in diabetics and patients with elevated serum lipids.

The frequency of serum insulin, carbohydrate, and lipid abnormalities was investigated in 25 patients with premature coronary heart disease (CHD). Their mean age was 40 years, ranging from 30 to 49 years. Known diabetics were excluded. Since obesity is known to increase serum insulin levels, obese patients were also excluded.

Serum lipids were determined in the fasting state. A glucose tolerance test was performed, and glucose, insulin, and free fatty acids at 0, 1/2, 1, 2, and 3 hour intervals were determined.

These studies showed abnormalities in the insulin response, glucose tolerance, or serum lipids (cholesterol and triglycerides) in 22 of the 25 patients. An abnormal insulin response, manifested by elevated levels, or normal levels with a delayed peak, was the most common abnormality occurring in 19 of the 25 patients. The mean insulin level at each interval was higher than those observed in a group of 21 normal control subjects. The total mean insulin output of the 25 patients with CHD, expressed as the area encompassed by the three hour curve was 17 mU-min, significantly higher than 9.1 mU-min in the control group ($p < .05$).

Although no patient had an elevated fasting blood sugar, 10 of the 25 patients had abnormal glucose tolerance according to the criteria of Wilkerson. The serum cholesterol or triglyceride values were elevated in 14 of the 25 patients.

Elevated lipids and abnormal glucose tolerance are recognized "risk" factors in CHD. The abnormal insulin response is another metabolic defect which may be a potential risk factor. Elevated insulin levels may also be important in atherogenesis since insulin has potent lipogenic properties.

* * *

Weight Gain and Serum Lipids in Relation To Small and Large Vessel Disease In Diabetics

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One hundred-twenty diabetics were studied with regard to age, sex, duration, family history, somatic index, weight gain, diet, treatment, triglyceride and cholesterol concentration in relation to the two dis-

tinguished vascular complications, the specific diabetic microangiopathy (small vessel disease) and the nonspecific atherosclerosis (large vessel disease).

Weight gain, whether followed by weight loss or not, was markedly associated with large vessel disease, to a lesser extent with small vessel disease, and to some extent with triglyceride elevation (particularly in women), less with cholesterol levels. When weight gain was followed by weight loss, large vessel complications were significantly less frequent than when the excess weight was maintained.

Patients with fasting blood sugar concentrations above 150 mg. per 100 ml. compared to those with concentrations less than 150 mg./100 ml. had a significantly higher mean triglyceride concentration, 6.3 mEq/liter compared to 5.1 mEq/liter ($p < 0.05$).

All patients with large vessel disease had a significantly ($p < 0.05$) higher mean triglyceride level (6.5 mEq/liter) than those without atherosclerotic symptoms (5.0 mEq/liter).

Diabetics with microangiopathy only had the highest prevalence of a positive family history of diabetes (40 per cent) and of coronary artery disease (32 per cent); in the group with large vessel disease the percentages were 15 per cent and 18 per cent, respectively. Correspondingly a positive family history of diabetes (21 per cent of all diabetics) was associated with a higher prevalence of small vessel complication.

A high prevalence of hypertension was noted, especially in the youngest diabetics and in those without other complications. The possibility of hypertension as an early manifestation of small vessel disease is discussed, as well as genetic and environmental influences on diabetes mellitus and its vascular complications.

* * *

Hyperosmolar Non-Ketoacidotic Coma In Diabetes

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This paper is based on experience with eight patients, five men and three women, with an average age of 63 years. The main features were related to the occurrence of severe hyperglycemia, hyperosmolarity, and dehydration in the absence of ketoacidosis. All patients were severely dehydrated and had arterial hypotension prior to or during the early stages of treatment. Four had evidence of intravascular clotting. Two had focal seizures, and three had Babinski's sign.

The urine contained 4+ glucose and no acetone. The average blood glucose was 940 mg./100 ml., CO₂ combining power 19.6, serum sodium 154, and serum osmolarity 361 mEq/liter. Blood urea ni-

trogen, initially high, decreased as rehydration was achieved. Diuresis was delayed due to the severe dehydration. However, the possibility of acute tubular necrosis should be considered early; it occurred in two patients.

The precipitating event is a sudden fall in the level of circulating insulin. Pancreatitis, diagnosed in one case, may be a predisposing factor. Reduced levels of insulin, together with increased carbohydrate intake cause severe hyperglycemia, which prevents the development of ketoacidosis. Hypernatremia and hyperosmolarity are due to loss of water in excess of salt. The resulting intracellular dehydration is responsible for the neurologic abnormalities. Hypotension predisposes to intravascular thrombosis.

Treatment is aimed at the correction of intracellular dehydration. In the initial phase, isotonic saline should be avoided. Half-normal saline or 2½—5 per cent dextrose are indicated, together with large doses of insulin and prophylactic heparin. Despite prompt treatment, four of the eight patients died. Previous reports have also stressed the high mortality. Increased awareness of this unusual form of coma together with improved therapy should lead to a reduced mortality in this potentially curable condition.

* * *

A New Oral Radioactive Glucose Tolerance Test

D-[1-¹⁴C] Glucose Utilization Measured by Monitoring ¹⁴CO₂ Expiration

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The biologic combustion of foodstuffs by cells is termed respiration and involves the oxidation of glucose by heterotrophic cells to carbon dioxide and water.

Carbon dioxide is produced at three different stages during the oxidative catabolism of glucose. During glycolysis (Embden-Meyerhoff scheme) a percentage of the phosphorylated glucose is diverted to phosphogluconic acid with (1) loss of one mole of CO₂ (Pentose pathway). The remaining phosphorylated glucose yields 2 moles of pyruvic acid from each of which (2) one mole of CO₂ is lost. Finally the remaining 2 carbon compound is (3) oxidized in the Krebs citric acid cycle to 2 moles of CO₂.

Following oral administration of 5 uc of D-[1-¹⁴C] glucose, we have measured hourly human expiration of ¹⁴CO₂ for periods up to 24 hours in normal individuals and in diabetic patients on and off medication, by a method described elsewhere.¹ We have compared the rate of radioactive CO₂ expiration with the standard oral glucose tolerance blood glucose levels.

In all diabetic patients tested, the exhaled radioactive carbon dioxide was lower at each individual interval than the corresponding values obtained from nondiabetic individuals. In many of the diabetics, the descending slope of the curve was delayed beyond that of the normal. The height of the peak of the ¹⁴CO₂ excretion curves from mild diabetics on the sulfonylureas was higher than peaks from more severe diabetics on insulin. When insulin is omitted from the diabetic for a 24 hour period, (a) the peak of the radioactive CO₂ excretion curve was markedly lowered, and (b) occurred later.

In several nondiabetic patients, a lowered ¹⁴CO₂ glucose utilization curve resulted from interference with glucose absorption.

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* * *

Studies on the Mechanisms of Adaptation to Starvation

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Adipose tissue triglycerides supply most of the energy required for survival during starvation. Carbohydrate utilization under these conditions is very low. The mechanisms responsible for these changes are unclear.

U-19425 ("pyrazole") is an inhibitor of lipid mobilization. The availability of such a material prompted its use as an experimental tool to assess control mechanisms during total starvation.

Three obese patients were subjected to varying periods of starvation. The pyrazole derivative was given to each for a portion of the fast. Administration of this compound caused acute decreases in the levels of plasma free fatty acids and ketones. These values gradually returned to pretreatment levels over the next three to four days in spite of continued therapy. No changes were seen during this phase of compensation in plasma levels of growth hormone, glucagon, cortisol, or in the urinary excretion of VMA.* Each patient was then given intravenous glucose and refed which resulted in high levels of endogenous insulin. Ketosis was rapidly corrected in all patients, but high levels of plasma free fatty acids persisted for several days. These data indicate that the ketonemic rebound was not due to excesses of growth hormone, glucagon, cortisol, catecholamines nor was it due to an inability to secrete insulin. It is suggested that these changes may have been due to a lipid mobilizing substance or an intrinsic adaptive mechanism within the fat cells.

*In each case, cessation of therapy resulted in the development of severe normoglycemic ketoacidosis. Increases in cortisol levels accompanied but did not precede the ketonemic rebound. Again, no changes were seen in the levels of growth hormone, glucagon, or urinary VMA.

* * *

Reduction in Mortality Due to Complications Of Myocardial Infarct with One Year Follow-Up of Survivors

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F.A.C.P., F.A.C.C., and K. D. Lee, M.D.,
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From the Fairview General Hospital, Cleveland, Ohio

The prognosis of the myocardial infarction can be predicted with the accuracy of 91.7 per cent using the discriminant analysis described by Hughes and his associates. Using this method the prospective study was undertaken with the object of (1) To follow the patients with myocardial infarction who were predicted to die but survived. These patients were followed for a minimum of one year. (2) To see what factors most affect the reduction in mortality rate of myocardial infarction treated in Coronary Monitoring Unit.

From October 30, 1964, to December 31, 1965, 291 patients were admitted to Coronary Monitoring Unit. Of these, there were 195 patients with proved diagnosis of myocardial infarction. One hundred and thirty-nine patients were male, and 56 patients were female. The ratio of men to women below 50 years was 10:1 and above 50 years was 2:1. About 60 per cent of the patients had previous history of angina or infarction. There were 116 patients with rhythm defect (59.5 per cent) and 56 patients with conduction defect (28.8 per cent). There was a total of 172 patients with conduction and/or rhythm defect (88.5 per cent). Ventricular Tachycardia was recorded in 24.6 per cent. There were 57 deaths, and seven patients died out of the Unit. The mortality rate of 26.6 per cent in the Monitoring Unit appears to be high because of selected admission of the patients to the Unit. Forty out of 57 patients (70.2 per cent) died within three days and 84.2 per cent died within seven days of admission. Fifty-one patients were resuscitated of whom nine survived and left hospital.

There were 86 patients who were predicted to die. Of these 86 patients there were 36 survivors reducing mortality by 41.9 per cent. During the same period 61 myocardial infarctions were admitted to the General Medical Floor; six were predicted to die, and all died. Greatest reduction in mortality occurred among those who had conduction or rhythm defect. There was also reduction in mortality among those who had hypotension or congestive failure. This is because of early detection and treatment by constant close observation of the patient and monitoring the venous pressure early in the course of the disease. The reduction in mortality was higher in males than females. Among men the reduction in mortality was highest in fourth decade and lowest in eighth decade. There was equal reduction in mortality among those who had history of angina, infarction, hypertension, or congestive heart failure.

* * *

Creatine Phosphokinase in Cardiovascular Disease

Alphonse C. Edmundowicz, M.D., (Associate), Jerome
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(both by invitation).

*From the Departments of Medicine and Pathology, West Virginia
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Detection of serum activity of various intracellular enzymes has come to play a major role in cardiovascular diagnosis. The ubiquitous nature of transaminases and dehydrogenases has been a disadvantage in this area. Phosphokinases are found in large quantities in muscle (myocardial and skeletal) and brain, thus are potentially more advantageous in cardiovascular diagnosis.

The kinetics of creatine phosphokinases (CPK) are complex, and most clinical procedures employ spectrophotometric methods with coupled reactions which are prone to insensitivity and occasionally, spuriously high values. Conn and Anido (*American Journal of Clinical Pathology*, 1966) have described a sensitive fluorometric method for assay of CPK, and this has been applied to over 150 patients with various myocardial, hepatic, pulmonary, and vascular diseases. Simultaneous determination of glutamic oxalacetic transaminase (GOT), lactic dehydrogenase (LDH), and hydroxybutyric dehydrogenase (HBD) activities were performed on each serum sample.

In 12 patients with acute transmural myocardial infarction, CPK elevations were noted as early as eight hours following chest pain. The pattern of GOT activity was very similar to CPK. Elevated serum levels of LDH and HBD persisted longer (10 days), suggesting a different mechanism of clearance. Normal CPK levels were found in patients with congestive heart failure, acute pulmonary edema, and chronic rheumatic, hypertensive, and arteriosclerotic heart disease. In patients with diverse hepatic and pulmonary diseases, CPK levels were normal, while simultaneous GOT, LDH, or HBD were often elevated. CPK appears to be as useful as GOT in uncomplicated myocardial infarctions. In patients with myocardial infarctions complicated by pulmonary disease or in differential diagnoses of chest pain, creatine phosphokinase is more organ specific and may be more useful than GOT in differentiating these conditions.

* * *

Electrocardiographic Phenomena During Temporary or Permanent Pacemaking in Patients with Complete Heart Block

Robert J. Marshall, M.D., (by invitation).

*From the Department of Medicine, West Virginia University
School of Medicine, Morgantown, West Virginia*

In the majority of patients with complete heart block in whom a pacemaker is inserted in order to control Stokes-Adams attacks or to increase the heart

rate, the ventricle responds exclusively to the electrical input from the device. Less frequently, after days to weeks of pacemaking, normal atrioventricular conduction is restored, and there is competition for control of the ventricle between the intrinsic and extrinsic mechanisms (iatrogenic parasystole). Other phenomena occur occasionally and are of considerable theoretical and practical importance. In a series of 60 patients with complete heart block followed closely in this Medical Center during the past five years, the following have been noted: (1) Retrograde conduction of electrical activity to the atria in the presence of persistent complete orthograde (forward) block. (2) Synchronization between the rates of discharge of the electronic pacemaker and of the sino-atrial node (isorhythmic dissociation, or accrochage). (3) Occurrence of unifocal ventricular premature contractions regularly interpolated between pacemaker-induced complexes, with periodic runs of ventricular tachycardia. (4) Ventricular capture by the pacemaker with consistency only when its input occurred during the supernormal recovery phase of the cardiac cycle. (5) Defects in the timing circuit of pacemakers causing "runaway pacemaker" with regular ventricular capture at a rate of 272 per minute (one example) and without ventricular capture (one example). These variant patterns were illustrated and their significance discussed.

* * *

Effect of Chronic Treatment with α -Methyl-Dopa on Renal Function in Hypertensive Patients

S. Mohammed, M.D., Ph.D., I. B. Hanenson, M.D.,
H. Magenheimer, M.D., and T. E. Gaffney, M.D.,
(all by invitation).

From the Division of Clinical Pharmacology, Departments of Internal Medicine and Pharmacology, The University of Cincinnati College of Medicine, Cincinnati, Ohio

Because of the frequency of renal disease in hypertensive patients, an important consideration in the selection of an antihypertensive agent should be its effect on renal function. Hexamethonium and guanethidine have been shown to reduce renal function in both the supine (S) and tilted (T) positions. In contrast to the effects of hexamethonium and guanethidine, Onesti et al. have demonstrated that intravenous injection of a single dose of α -methyl-dopa (α -MD) causes essentially no change in renal function of hypertensive patients. However, there are no reports on renal function during chronic oral

treatment with α -MD in the upright position. The influence of chronic treatment with α -MD on renal function was, therefore, studied in eight hospitalized patients with essential hypertension. Blood pressure (BP) and renal function were measured in the S and T positions during oral treatment with placebo and α -MD. Treatment with α -MD significantly reduced the diastolic BP on the ward by 23 mm Hg in the S and 27 mm Hg in the erect position. The effects (mean \pm S.E.) of treatment of α -MD and placebo on renal function were as shown in Table 1 on this page.

These results indicate that the reduction in BP produced by chronic oral treatment with α -MD is not associated with an impairment in renal function in either the S or T positions. In fact, chronic treatment with α -MD significantly increases renal plasma flow and decreases renal vascular resistance.

* * *

Renal Artery Aneurysms and Hypertension: A Review of 51 Cases

Kathryn L. Popowniak, M.D., (by invitation), Ray W. Gifford, Jr., M.D., F.A.C.P., Ralph A. Straffon, M.D.,
Thomas F. Meaney, M.D., and Lawrence J. McCormack, M.D., (latter three by invitation).

From the Cleveland Clinic Foundation, Cleveland, Ohio

During the last 15 years, at Cleveland Clinic, 51 patients (30 women and 21 men) have had renal artery aneurysm; in 48 diagnosis was from renal angiography with or without operation, 1 from operation only, 2 from postmortem examination. The average age at the time of diagnosis was 53 years. Two or more renal artery aneurysms were found in each of nine patients, including seven who had bilateral aneurysms. Ten patients also had aneurysms in other arteries. Only one renal artery aneurysm ruptured, occurring after translumbar aortography.

Forty-four (86 per cent) of the 51 patients had hypertension (systolic blood pressure higher than 150 and/or diastolic pressure higher than 100 mm. Hg) including 10 patients with only systolic hypertension. Occlusive arterial disease in one or both renal arteries was associated with aneurysms in 15 patients, 13 of whom had diastolic blood pressures of 100 mm. Hg or higher: seven had diastolic pressures higher than 120. Group 2 hypertensive retinal changes were observed in four of these patients;

TABLE 1. (Dr. S. Mohammed, et al.)

	Placebo		α -Methyl-Dopa	
	Supine	Tilt	Supine	Tilt
Blood Pressure mm Hg	199/128	175/125	178/119	144*/104*
Urine Volume ml/min .....	.83 \pm .14	.33 \pm .05	1.2 \pm .18*	.59 \pm .13*
Glom. Filtration Rate ml/min	71 \pm 6	58 \pm 10	76 \pm 9	66 \pm 7
Renal Plasma Flow ml/min	302 \pm 30	233 \pm 40	350 \pm 54	306 \pm 42*
Renal Vasc. Resist. mm Hg/ml/min .....	.34 \pm .06	.48 \pm .11	.28 \pm .05*	.27 \pm .05*

*denotes $P < 0.05$ on paired comparison with placebo in the same position.

two had group 3 changes; one had malignant hypertension (group 4). Of 36 patients with no associated occlusive diseases in the renal arteries, only 21 had diastolic blood pressures of 100 mm. Hg or higher; nine had diastolic pressures higher than 120. Six of 31 patients who had ophthalmoscopic examinations had group 2 retinal changes; two had group 3 changes; none had malignant hypertension. Aneurysms of the renal artery apparently are not often associated with severe hypertension, unless there also is occlusive disease of the renal artery.

* * *

Amebiasis: An Endemic Disease in Southwestern Pennsylvania

Robert Schwartz, M.D., F.A.C.P.

From the Centerville Clinic, Fredericktown, Pennsylvania

Infestation by the protozoan parasite, *Entamoeba histolytica*, is much more common than is generally appreciated by most practicing physicians. Since this is not a reportable disease, its incidence can only be judged from surveys. Many of these have been conducted in various parts of the United States with an average incidence of 10 per cent. The type of amebic infestation which is endemic in this country must be distinguished from the amebic dysentery seen in tropical climates.

During the years 1945 to 1955, approximately 1,500 cases of amebic infestation were detected at the Veterans Hospital in Aspinwall, Pennsylvania. (A survey study of 300 routine admissions revealed a 20 per cent incidence of infestation.)

At the Centerville Clinic in Fredericktown, Pennsylvania, 657 patients with amebiasis were detected from May, 1955 through August, 1966. Fifty families of patients were studied, in whom *E. histolytica* was found in 150 cases, most of them being asymptomatic carriers. Incidence varied from two to seven per family with an average of three.

The symptoms of amebiasis are protean and non-specific, consisting mainly of gastrointestinal disturbances, weakness, irritability, and emotional instability. A palpable liver is commonly found on examination. For adequate stool examination, particularly in adults, a purged specimen should be obtained in order to obtain fecal contents from the right side of the large bowel. A mild eosinophilia (3 to 5 per cent) is often noted. The complement fixation test is only of value in extra-colonic infestation (e.g., amebic hepatitis), which is very rarely seen in endemic amebiasis. Varied methods of treatment are available and effective, but relapse is common, indicating the need for follow-up stool examinations periodically.

Summary: Amebiasis is an important endemic disease in Southwestern Pennsylvania, but it is rarely recognized because of a lack of awareness on the

part of the physicians and a paucity of laboratory technicians with adequate training in parasitology.

* * *

Lung Abscess

Richard L. Witt, M.D., (by invitation), John L. Friedman, M.D., F.A.C.P., and Morton Hamburger, M.D., F.A.C.P.

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Lung abscess is a disease entity which has been described since antiquity. Though antimicrobial agents have been in use for more than 20 years, lung abscess is still prevalent and presents a diagnostic and therapeutic problem.

One hundred and twenty-seven patients on the medical service of the Cincinnati General Hospital were diagnosed as having lung abscess during the period from 1949 through 1963.

In this series, severe illness, such as uremia, stroke, and hepatic coma was often accompanied by an occult lung abscess. Empyema, meningitis, brain abscess, and severe malnutrition accompanying lung abscess gave a very poor prognosis. When a single bacterium, rather than mixed flora, was cultured the prognosis was less favorable. Bronchogenic carcinoma and granulomatous infections were clinically indistinguishable from lung abscess, but certain clues were found to aid in the differential diagnosis.

In the absence of severe complicating factors, antibiotic therapy was uniformly successful in the treatment of lung abscess and surgical intervention was rarely necessary.

These factors were discussed and illustrative cases were presented.

* * *

Some Factors Affecting Relationship of Maximal Expiratory Flow to Lung Volume in Health and Disease

N. LeRoy Lapp, M.D.*, and Robert E. Hyatt, M.D.**

**From the Appalachian Laboratory For Occupational Respiratory Diseases (ALFORD) and the Department of Medicine, West Virginia University School of Medicine, Morgantown, West Virginia; and **Section of Physiology, Mayo Clinic and Mayo Foundation, Rochester, Minnesota.*

Flow-volume (FV) curves of forced expiration were obtained in normal subjects and in patients with selective lung diseases. The slope of the curve from 50 to 75 per cent of vital capacity expired for normal subjects had a mean value of 2.36 ± 0.80 liters per second per liter exhaled. No significant difference was found between the mean slopes for normal males and normal females. The FV slope was reasonably effective in distinguishing the normal subjects from those with lung disease but did not provide a clear-cut separation between the subjects with asthma and those with other obstructive disease.

A time constant of lung emptying, calculated as

the reciprocal of the FV slope, correlated well with the product of pulmonary airflow resistance and static lung compliance. This relationship was valid for subjects with lung disease in which either resistance or compliance or both were altered.

This investigation was supported in part by Research Grants OH-0146 and 5TI GM-89 from the National Institutes of Health, Public Health Service.

* * *

A New Variant of Klinefelter's Syndrome With a Presumptive Deleted Y Chromosome

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(by invitation).

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In 1959 Jacobs and co-worker first described the cytogenetic abnormality (47/XXY Karyotype) associated with the classical form of Klinefelter's syndrome. Since then many cytogenetic variations have been noted, most of which involve aneuploidy of the X chromosome. Other chromosomal variants in this syndrome include such things as mosaicism, aneuploidy of the Y chromosome, and structural changes in the X chromosome. One case with Klinefelter's syndrome has been described in which a postulated break occurred in the Y chromosome with translocation of its fragments to two other chromosomes.

The purpose of this paper is to report a case of Klinefelter's syndrome which is atypical in terms of both karyotype and phenotype. Cytogenetic studies showed the patient to be chromatin positive with a chromosome count of 47. Two X chromosomes were present, but the Y chromosome appeared much smaller than normal. It was felt that this Y chromosome represented a deletion of the long arms with no evidence of translocation of the deleted material. Chromosome studies performed on four of his male sibs showed that all had a normal karyotype. Their Y chromosomes were of standard size which, therefore, suggested that the proband's Y was not a marker chromosome. In addition to the usual findings of small testes and gynecomastia the patient displayed microcephaly, asymmetry of the face with unusual facies, and severe mental retardation. To the best of our knowledge, this case is the first to show a deleted Y chromosome associated with Klinefelter's syndrome.

Further comments were made concerning abnormalities involving the Y chromosome, and the possible relationship of this to various developmental defects.

* * *

A Clinical and Structural Study of the Ehlers-Danlos Syndrome Together with The Marfan Syndrome

Richard M. Goodman, M.D., Dante G. Scarpelli, Ph.D.,
M.D., (both by invitation), and Charles F.
Wooley, M.D., (Associate).

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Several of the known heritable disorders of connective tissue share common clinical features, but of these the Marfan syndrome and the Ehlers-Danlos syndrome seem to possess the greatest similarities. This report describes for the first time a patient with both of these disorders. Evaluation of other family members revealed that a sib of the proband was also affected with both disorders while other family members had either one or the other of these syndromes.

A biopsy in the proband of healing wound tissue showed, on electron microscopy, marked decreased amounts of collagen together with alterations in the ribosomal configuration in fibroblasts, when compared to three normal individuals matched for sex, age, and race. Other fine structural changes were observed and these were discussed with respect to their absence in the control tissues. Though these observations are thought to be related to the Ehlers-Danlos defect, other clinical findings will be presented showing common similarities with regard to these two genetically determined syndromes.

* * *

Some Functions of Extracellular Volume as Stimuli of Sodium Excretion

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Charlotte Orlando, and Gholam Shamlou, M.D.,
(latter three by invitation).

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Youngstown, Ohio, and the Department of Medicine, Uni-
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Pennsylvania*

Regulators of the extracellular volume remain unclear. These experiments were undertaken to determine some functions of the extracellular volume as stimuli of sodium excretion. Studies were performed on normally hydrated, hydropenic, and salt restricted normally hydrated dogs, who were loaded with both vasopressin and DOCA®. Saline was infused at two different rates in paired experiments. The time required to achieve maximum rates of sodium excretion was delayed in both hydropenic (84 minutes) and salt restricted normally hydrated (76 minutes) animals when compared to the normally hydrated (54 minutes) animals ($P < .025$, $< .05$, respectively) regardless of infusion rate. At equal volumes infused, or equal volumes retained, the faster infusions evoked greater increases in urine flow, UNaV and Cosm than slower infusions in all groups. The differences were not related to changes

in GFR or ERPF. Plasma volume increased no more in hydrated than hydropenic animals. However, maximum rates of sodium excretion were higher in hydrated animals. The regression plot of ΔUNaV on $\Delta\text{plasma volume}$ showed no correlation. In hydropenic animals, cumulative fluid retained continued rising after sodium excretion stabilized ($P < .01$), while plasma volume remained relatively stable suggesting the continued accumulation of fluid was probably extravascular. $\Delta\text{Fluid balance}$ could not be related to ΔUNaV .

Gradually increasing or decreasing the rate of expansion of the extracellular volume produced changes in sodium excretion in the direction of alteration followed by stabilization until the next rate change.

These observations suggest that (1) the initial state of the extracellular volume influences the rapidity and/or magnitude of the response, (2) expansion of plasma or extravascular volume, per se, are not the important stimuli to sodium excretion, (3) a disequilibrium between the vascular and extravascular spaces induced by a change in expansion probably is an important stimulus to sodium excretion.

* * *

Studies of Female Hirsutism

Robert L. Folk, M.D., (by invitation), Ralph G. Wieland, M.D., F.A.C.P., Nichols Vorys, M.D., (by invitation), and George J. Hamwi, M.D., F.A.C.P.

From The Ohio State University College of Medicine, Columbus, Ohio

Forty-four females with hirsutism but without virilization were evaluated clinically and with studies of urinary excretion of testosterone glucuronoside (TG), 17-ketosteroids, 17-hydroxycorticosteroids, and unconjugated 11-hydroxycorticosteroids. In addition, in 35 patients the ovaries were inspected by culdoscopy. Steroid determinations were performed in the control state, after adrenal suppression, and after ovarian stimulation with gonadotropin plus adrenal suppression. Three patterns of TG excretion were observed: (1) In 25 patients control TG excretion was elevated and decreased to normal female levels during adrenal suppression and ovarian stimulation; (2) In 11 patients normal TG excretion was found throughout the study; (3) In 8 patients TG excretion increased with ovarian stimulation. All three patterns of response were seen in patients with abnormal ovaries which suggested that the ovarian abnormalities in some of these patients may be secondary to excessive circulating androgen. This androgen or its precursor may be of adrenal origin. Proper biochemical classification of hirsute females is essential for the management of these patients.

* * *

Two Cases of Medullary Thyroid Carcinoma Causing Cushing's Syndrome

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From the Cleveland Clinic Foundation, Cleveland, Ohio

Two patients are described with Cushing's syndrome and medullary thyroid carcinoma.

Case 1: A man 33 with the clinical and laboratory findings of Cushing's syndrome and a thyroid nodule. B.P. was 120/80. Urinary 17-OH steroids were 19.2 mg./24 hrs. base line and 12.6 mg./24 hrs. after dexamethasone 2 mg. q6 hrs. for two days. At laparotomy, bilateral pheochromocytomas and adrenocortical hyperplasia were found. Plasma ACTH activity was 1.5 milliunits (mU)/100 ml. after adrenalectomy and before thyroidectomy, and was negligible three days after thyroidectomy. The thyroid tumor was a medullary carcinoma which contained ACTH activity of 0.18 mU./Gm. (Dr. G. Liddle)

Case 2: A woman 26 with the clinical and laboratory findings of Cushing's syndrome and a thyroid mass. Urinary 17-OH steroids were 9.2 mg./24 hrs. base line and 6.4 mg./24 hrs. after dexamethasone 2 mg. q6 hrs. for two days. The thyroid carcinoma and lymph node metastases were of a unique mixed medullary-follicular type. ACTH activity in metastatic tumor was 20.8 mU./Gm. Adrenalectomy revealed bilateral cortical hyperplasia.

These are apparently the first two cases of thyroid carcinoma with proven ACTH activity. Both were of the uncommon medullary type. There are three other reports of Cushing's syndrome associated with thyroid carcinoma; at least one of these is also of the medullary type. Medullary thyroid carcinoma is unique among thyroid neoplasms in its familial incidence, association with pheochromocytoma, and production of amyloid. It may also be unique in its production of ACTH.

* * *

A Comparison of Iodine-125 and Iodine-131 As Agents for Thyroid Uptakes

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From Washington Hospital, Washington, Pennsylvania

Thyroid scans using ^{125}I are clearly superior to those using ^{131}I . The physical characteristics of ^{125}I allow for better localization and resolution and lower background than ^{131}I . This is achieved with a tenfold reduction in dose to the thyroid.

Sound physical reasons exist for the belief that ^{125}I is not a suitable agent for thyroid uptakes. Consequently, the current practice is to administer separate doses of ^{131}I for uptakes and of ^{125}I for scans. The double dose technique is cumbersome and time consuming. It would be of distinct ad-

vantage to be able to do ^{125}I uptakes along with the ^{125}I scans. Recent work suggests that valid uptakes can be obtained with ^{125}I by proper control of the geometry of the standard. We have attempted to confirm this work to our own satisfaction. Early attempts in our laboratory showed little correlation between simultaneously performed ^{131}I and ^{125}I uptakes.

A series of simultaneously performed ^{131}I and ^{125}I uptakes without controlling the ^{125}I standard geometry will be compared with a similar series in which the geometry of the ^{125}I standard was altered to produce equivalent uptakes in the 'normal' situation. The results indicate that reasonable correlation between ^{131}I and ^{125}I uptakes can be obtained only if great attention is paid to the approximate size of the thyroid gland and appropriate correction of the standard geometry is made. If this can be controlled the only uncontrolled parameter is the depth of the thyroid gland. Theoretical considerations outlining the significance of this factor were discussed.

* * *

The Determination of the Thyroxine Iodine Content of Serum Contaminated with Organic Iodines: A New Method Based on Gel Filtration

Jeffrey S. Shultz, B.S., (by invitation), and
John E. Jones, M.D., F.A.C.P.

From the Department of Medicine, West Virginia University Medical Center, Morgantown, West Virginia

The iodinated radiographic contrast agents can prevent the laboratory documentation of hyperthyroidism or hypothyroidism for periods of a few weeks to several years. The problems cannot be solved by any of the readily available thyroid function tests (PBI, BEI, T_4 by Column or Free Thyroxine). BMR and resin T_3 uptake determinations are influenced by other disease states and are often inaccurate.

We have developed a simple and rapid method of separating thyroxine from various iodinated radiographic contrast media. Serum samples are applied to Sephadex G-25 columns equilibrated with 0.015M NaOH and the columns then eluted with

0.025M, pH 8.6 Tris buffer, which elutes contaminating iodinated substances. The NaOH equilibrated column splits thyroxine from its binding proteins, and the freed thyroxine is adsorbed to the Sephadex and not eluted by the Tris eluent. Thyroxine is thereafter removed from the column with 2M NH_4OH and dried in vacuo. The dried fraction is redissolved in NH_4OH and the "thyroxine iodine content" (T_4IC) quantitated by an automated ^{127}I chemical method (Auto Analyzer).

Our normal PBI range by Auto Analyzer is 4.5-9.5 μg per cent. The T_4IC of 40 euthyroid controls was 6.1 ± 0.9 (S.D.) μg per cent; of 15 hyperthyroid patients 15.1 ± 3.3 μg per cent; and of 10 hypothyroid patients 2.3 ± 0.5 μg per cent. PBI and T_4IC determinations on serum from euthyroid individuals before and after various x-ray studies utilizing iodinated contrast agents were as shown in Table 1 on this page.

In addition, preliminary studies on the in vitro addition of Gastrografin®, Cholografín®, Renografin®, Dionosil®, Lipiodol®, Ethiodol® and Pantopaque® to serum indicate separation of these compounds from thyroxine.

This method shows promise of solving a long-standing clinical problem.

* * *

Critique of Medical Pre-Employment Examinations

Frank L. Bauer, M.D., F.A.C.P.

From the Medical Department, United States Steel Corporation, Pittsburgh, Pennsylvania

The purpose of this study was to see what could be learned from medical pre-employment examinations done for Industry. Some of the questions asked were: (1) Does the present type of medical pre-employment examination really select the better applicants and conversely can it identify and reject less qualified applicants? (2) What parts of the procedure are meaningful and predictive, and which add nothing? (3) After being hired, are there objective work performance criteria that will identify the productive employee? (4) Is it worth while

TABLE 1. (J. S. Shultz and Dr. John E. Jones)

X-ray Agent Used And No. of Patients	Before X-ray Agent		After X-ray Agent	
	PBI μg %	T_4IC μg %	PBI μg %	T_4IC μg %
Telepaque (12)	7.1 ± 1.5	6.6 ± 1.6	240 — 1600	6.6 ± 1.9
Hypaque (7)	7.3 ± 0.7	6.4 ± 1.1	250 — 2100	6.0 ± 0.8
Pantopaque (6)	6.7 ± 2.2	5.6 ± 2.0	10.5 — 124	6.1 ± 2.0
Cholografín (4)	7.4 ± 0.6	6.9 ± 0.7	640 — 7920	6.9 ± 1.0

doing a medical pre-employment examination on all categories of workers?

Materials Available for Study. Available for such a study were all new hires in the central office of a large Pittsburgh located corporation. About 180 new employees were hired each month. Most of these were young female clerical workers, and it was decided to use this highly homogeneous group for the study.

For a criterion of work performance the number of scheduled hours of work missed and number of unauthorized absences from the job were used. These were selected because irrespective of how proficient a worker is, she cannot be successful when absent from work.

The data to be reported are drawn from 200 consecutively hired young female clerical workers all of whom were personally examined by this writer prior to their employment. The observation period of each employee was 12 consecutive months.

Method. All applicants were physically examined and medically interviewed. Those not rejected for major medical causes were asked to complete a medical history questionnaire with the responses limited to either *yes* or *no* factual answers. From this questionnaire the following characteristics were selected for a test of their predictability for absenteeism:

1. Over or under 21 years of age.
2. Marital status.
3. Children.
4. Any previous job held longer than 12 months.
5. History of repeated miscellaneous minor medical treatment.
6. Taking medicine now.
7. History of accidents.
8. History of overt tension or situational anxiety.
9. History of neuropsychiatric treatment.
10. History of tension headache.
11. History of indigestion or ulcer-like symptoms.
12. Presence of "menstrual cramps" with periods.
13. Presence of organic disease.

The presence or absence of these characteristics in each individual were correlated with that employee's standing as to number of hours work missed and number of unexcused absences.

Findings and Interpretation. Those employees who have symptomatic menstrual cramps, a history of indigestion or ulcer-like symptoms, have had previous miscellaneous minor medical treatment or are taking medicine now, and in addition are married and have children are almost sure to be chronic absentee workers. Conversely, the employee who

has the fewest of these characteristics and who also has tension headache, had held a previous job 12 months or longer and who has some history of situational tension is the best candidate for a low rate of absenteeism.

Although not as clear-cut as the foregoing characteristics, over 21 years of age and those few who did have a history of treatment for anxiety type neuropsychiatric problems seem to be favorable findings and are suggestive that such applicants would be in the low absentee rate category. Among the 200 subjects those with a history of accidents or who had organic disease were so few in number that no conclusion could be drawn.

* * *

Benign Familial Erythrocytosis — A 24-Year Study

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Four siblings in one family of Italian extraction with benign erythrocytosis have been followed for 24 years. When first examined in 1942, the three sisters and their brother were 24 to 34 years of age. On physical examination all four patients were plethoric, and two of them had mild splenomegaly. The hematocrit values ranged from 55 to 72 per cent, and all showed a marked increase in red cell mass. None had leukocytosis or thrombocytosis. Repeated examinations over the years have disclosed no evidence of renal, cerebellar, or endocrine disorders. Hypoxemia was not present. The patients were remarkably free of significant symptoms and had no signs of thromboembolic disorders in spite of increased blood viscosity. Vigorous treatment with phlebotomies gave no subjective improvement and was discontinued after a few years. Treatment with P³² in one patient caused thrombopenia, leukopenia, and minimal reduction in red cell mass. The father and mother were dead, but were reported to have had normal coloring. Three children of two of the patients had normal blood counts.

The cause of "benign familial erythrocytosis" is unknown. The mode of inheritance is not clear. It is characterized by a nonprogressive increase of red cell mass and seems compatible with a normal life span. Charache, Weatherall, and Clegg recently reported mild erythrocytosis in a family due to the presence of an abnormal hemoglobin (Chesapeake), which has an increased affinity for oxygen. Our four patients had normal adult hemoglobin.

* * *

(Continued on next page)

Thrombotic Thrombocytopenic Purpura — A Curable Disease?

John B. Hill, M.D., (Associate), and
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Since the initial description of thrombotic thrombocytopenic purpura by Moschowitz in 1925, almost 300 cases of this disease have been reported in medical literature. In a review of these patients, only 15 are alive and apparently cured. Therapy in these 15 cases varied, but eight received steroids in combination with splenectomy.

The purpose of this paper is to report three additional cases of thrombotic thrombocytopenic purpura in whom a cure has resulted following the combination of massive corticosteroid therapy and splenectomy. At the present time, they have survived nine, four, and one year, respectively, and have had no additional symptoms and have required no additional treatment.

All three are women, ranging in age from 22 to 34 years at the onset of their disease. All have had the typical clinical triad of thrombocytopenic purpura, hemolytic anemia, and neurologic manifestations. In every case, helmet cells were present in the peripheral blood prior to splenectomy, and the typical hyaline thrombi were demonstrated in the splenic vessels. None had a positive LE preparation or pathologic changes of lupus erythematosus.

Massive corticosteroid therapy was employed initially in all three cases but incomplete response occurred. After splenectomy, prompt clinical and laboratory remission resulted, and corticosteroid therapy was gradually tapered and discontinued without reexacerbation of the disease. One woman, three months pregnant at the onset of her disease, completed her pregnancy despite her illness and resultant therapy and delivered a normal child.

Because of our experience, we have performed a splenectomy earlier in the course of each successive case. In the most recent case, the operation was performed on the second hospital day. In a patient in whom the classic syndrome of this disease is present and the typical red cell morphologic changes are present, large doses of corticosteroids should be used promptly and should be followed by early splenectomy. We feel that, if this therapeutic approach is carried out early in the course of the disease, the number of permanently cured patients will be significantly increased.

* * *

Periostitis Deformans Secondary to Massive Doses of Fluoride In Multiple Myeloma

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Six patients with multiple myeloma have been treated with massive doses of sodium fluoride for 12 to 24 months. X-rays of the skeleton have been taken at 3 month intervals. All of these patients at the beginning of the study were well controlled by 1-phenylalanine mustard. The first definite radiological change was observed after eight months of therapy. This consisted of a thin irregular calcification of the periosteum of the long bones. In three patients, this has progressed to an extensive degree of involvement of the appendicular skeleton. The medullary cavity of the long bones has shown no tendency to become narrowed. The axial skeleton has failed to show sclerotic changes. One patient, after 20 months of fluoride therapy, suddenly began to develop nodules of the periosteum. These were 1 cm. in diameter and about 0.5 cm. thick. The patient described the overlying skin as being painful. The nodules enlarged over a period of several weeks. Gradually these would become painless but to date have shown no tendency to regress. These nodules have occurred on the phalanges, clavicles, ribs, and tibia.

These changes are more consistent with periostitis deformans as described by Soriano in 1952 and 1965 than with the earlier descriptions of subacute fluorosis, as described by Roholm and by Singh, which were secondary to industrial exposure or to contaminated water supplies. Soriano estimated that some of his patients had consumed in wine as much as 66 mg. of fluoride daily for years. It should be noted that this predominately periosteal lesion more closely parallels the result of fluorosis in some animal experiments than does the subacute fluorosis as observed in humans secondary to water contamination or to industrial exposure.

It appears that a small dose of fluoride over long periods favors the changes as described by Roholm and observed by Singh. The massive doses as given in this group of patients favors a rapid predominately periosteal reaction.

* * *

The Effect of ABO Blood Group Incompatibility on Renal Homotransplantation In Man

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The study includes 24 patients who received renal homografts from ABO blood group incom-

patible donors. Twelve patients were of major, and 12 were of minor incompatibility. Clinically, the patients with the major incompatibility did badly in terms of survival of the patients and of the homografts; frequency of immunologic rejection crises; failure in homograft function; and the development of arterial hypertension. In contrast, the patients with minor incompatibility compared favorably with those with no ABO blood group incompatibility. Nine of the 12 patients with major incompatibility were dead within three months after transplantation. The pathology in their homografts revealed acute and fulminant rejection, which resulted in renal artery thrombosis and parenchymal necrosis. Of the remaining three patients, one is still living (16 months post-transplantation), and two were dead, nine and 14 months after transplantation. The corresponding immune A and/or B isoagglutinin(s) titer in six patients with major incom-

patibility showed the following pattern: (1) An initial fall after transplantation, (2) a gradual rise, (3) a more substantial rise after removal of the homograft; this occurred despite continuing immunosuppression.

Our study demonstrated the following points concerning ABO blood group incompatibility in renal homotransplantation:

(1) Major incompatibility between donor and recipient commonly resulted in early homograft failure.

(2) Acute immunologic rejection in the homografts was responsible for the early failure.

(3) The significance of the A, B isoagglutinin in rejection is suggestive, but not proven.

(4) Minor incompatibility in ABO blood group is permissible in donor selection.

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CARDIAC ARREST. — It has often been emphasized that the establishment of an airway and inflation of the lungs, to relieve anoxia and hypercapnia, is as important in resuscitation as restoration of the circulation. It is the principal purpose of this paper to emphasize that treatment of acidosis is the next priority in the management of cardiac arrest. Correction of acidosis may be essential for restoration of heart-beat, though other measures, such as the administration of adrenaline and of calcium salts, may be valuable. Finally, of course, it is important to treat the cause of the arrest. . . .

The management of six earlier cases of circulatory arrest is compared with six cases treated after the introduction of external cardiac massage and of acid-base measurements. In the latter cases cardiac function was restored more often, although resuscitation was attempted in less than optimal circumstances. Acid-base measurements were obtained in four of the latter cases. Severe metabolic acidosis, present in two cases, was completely corrected by administration of intravenous sodium bicarbonate solution. Severe respiratory acidosis was present in one case. In the fourth case, in which the period of circulatory arrest was very short, there was no acidosis.

External cardiac massage permits the earliest possible treatment of cardiac arrest. Metabolic acidosis is often the result of cardiac arrest irrespective of cause, and may be so severe that it prevents restoration of the heart-beat. It may be corrected by the intravenous administration of sodium bicarbonate solution. — John S. S. Stewart, M. B., CH. B., F. R. C. S., Oxford, England: *British Medical Journal*, 1:476-479, February 22, 1964.

A Baedeker for Fat-Controlled Diets

IV. The Role of the Physician and Dietitian In Changing Food Habits

HELEN B. BROWN, Ph. D.,* and MARILYN FARRAND, M. S.†

DIET THERAPY is becoming more complex; interest is now extended from the nutrients, protein, fat or carbohydrate, to their various components — amino acids, fatty acids or saccharides. Information on the effects of trace elements in metabolism is increasing; knowledge of the relationship of medication to nutrient needs is expanding. As insight into the role of nutrition in medicine accumulates, increased communication between the physician and dietitian becomes more important.

By explaining these interrelationships to the dietitian, the physician can help her transfer nutrient needs into foods to provide the best dietary treatment. The dietitian, in turn, may give the physician pertinent information about a patient acquired during the nutritional interview. Thus, successful diet therapy is most likely to result from this exchange of information among the physician, dietitian, and, of course, the patient.

The main role of the physician in dietary treatment of hyperlipidemia is its overall management, determination of the type of lipid abnormality, the diet prescription and interpretation of subsequent blood lipid changes. He should be familiar with the underlying principles of food selection for fat-controlled diets and the general characteristics of fat in the various food groups — animal products, fats and oils, and low-fat foods — described in the third Heart Page (Table 3). He need not be burdened with details about specific foods nor give food suggestions.

The physician establishes the dietitian's role in the therapeutic program when he discusses dietary treatment with the patient in her presence. His

support and re-enforcement of her nutritional advice is essential, for he has a strong influence on patient cooperation. If the physician begins dietary treatment while the patient is hospitalized, he provides opportunity for demonstration as well as education and adjustment. Once therapy is initiated, only a small amount of his time is needed for monitoring this phase of the treatment. The dietitian can be responsible for the detailed, long term program of changing food habits.

The physician can rely on the dietitian to transform his diet prescription into specific foods. Professionally, she is trained in the fundamentals of food and nutrition, the knowledge of food products and their composition, and their preparation and use at the table. She is aware of the role of diet in the treatment of disease and the difficulties in changing food habits. She can advise how to meet nutritional requirements when certain foods are omitted or limited. When fat-controlled diets must be modified as to protein, carbohydrate or sodium content, the dietitian can adjust the diet plans accordingly. For example, a diabetic diet may be planned to incorporate the principles of the vegetable-oil food pattern along with controlled protein and carbohydrate content.

A patient's diet adherence depends a great deal on the skill with which the dietitian adapts it to his individual needs. Sometimes meals away from home need special planning; suggestions for packed lunches and dining out are frequently required. Patients on modified diets may miss a favorite food or complain about a monotonous menu. Many favorite dishes can be adapted to the diet plans; different food combinations and new methods of food preparation may be utilized. For example, a flavorful gravy for a low-fat diet can be prepared by chilling meat drippings to remove fat; "creamed" chicken is also possible in a low-fat diet. The dietitian can offer

The Heart Page is a periodic feature of *The Journal* containing brief, practical comments on subjects of immediate importance to practicing physicians. The comments are solicited by the Professional Education Committee of the Ohio State Heart Association.—Ed.

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suggestions for preparing foods with polyunsaturated margarines and oils for the vegetable-oil food pattern, and offer tips on baking when egg yolks are omitted.

Homemakers are often perplexed by the variety of processed foods sold in the supermarket and wonder if they may be used in modified diets. They need help with interpretation of labels and advice about particular ingredients, such as the kind of fat in the product. Soups, frozen entrees, low-fat cheese, mixes and packaged cookies are among the popular items about which information is needed.

Individual support and encouragement of the patient during dietary treatment is one of the dietitian's most important functions. During a single diet instruction it is impossible to change food habits which have been developed over a lifetime. Continuing interviews are essential. With her knowledge of the particular patient's problems and way of life, acquired over a period of time, the dietitian can help him adjust to his new food pattern.

How the dietitian converts the diet prescription into foods for fat-controlled diets will be discussed in the next two Heart Pages.

BROWSING RECENTLY IN AN ANTIQUE SHOP in Newport, Ky., a member of a University of Cincinnati Medical Center cardiology team was startled by a 19th century bottle with a 20th century look. The antique bottle's stopper was just like the widely-publicized caged ball valve developed in the late 1950's as a replacement for failing human heart valves. Dr. David C. Schwartz bought the bottle, investigated its unique stopper, and found that the device was, indeed, like the modern device known as the "Starr-Edwards valve" which is hailed as a milestone in life-saving heart surgery.

The curious bottle is of clear flint glass. Its stopper is a pewter cage with a marble ball. J. B. Williams of New York City was granted U.S. patent No. 19323 for it on Feb. 8, 1858. Dr. Schwartz found that in his patent report Mr. Williams indicated the ball valve was not his idea. He wrote, "I would state that I am aware that a ball valve is not new and I lay no claim to it in its general application; but what I do claim as a new article of manufacture is . . . a bottle stopper." The receptacle is known as a bar bottle. The marble ball moves away from the mouth of the stopper when the bottle is tilted—the same principle which serves so well today in allowing flow of blood from the heart through the artificial ball valve.

The bottle now is in the collection of Dr. and Mrs. Samuel Kaplan. Dr. Kaplan, UC professor of pediatrics and director of the department of cardiology, Children's Hospital, heads the team on which Dr. Schwartz's special role is heart catheterization and diagnostic studies on patients being considered for surgery. A University of Cincinnati instructor in pediatrics, Dr. Schwartz is in his third year as a U. S. Public Health Service cardiology fellow.

Said Dr. Schwartz: "Although it is generally true that many advances in clinical medicine have resulted from the application of new technics, acknowledgment of the application of old technics is also warranted . . . This curious bottle stopper of a century ago reminds us that the caged ball valve of today is an old idea with yet another new and lifesaving application." — *University of Cincinnati Medical Center*, NEWS RELEASE, March 2, 1967.

A Clinicopathological Conference

From The Ohio State University Hospital, Columbus, Ohio

Edited Under the Auspices of the Ohio Society of Pathologists

J. B. McMILLAN, M. B., Ch. B., *President*

PRESENTATION OF CASE

THE PATIENT, a 58-year-old white man, had been in his usual state of good health until several years prior to admission to the Ohio Tuberculosis Hospital, when a dry cough developed that slowly became productive of increasing amounts of white sputum. He then noted increasing shortness of breath and dyspnea on exertion and a moderate weight loss. He consulted his local physician, who noted probable active tuberculosis on a chest film, and the patient was admitted to the local sanatorium. The diagnosis of active pulmonary tuberculosis was confirmed with positive smears and cultures, and he was treated with isoniazid and streptomycin. His shortness of breath, productive cough, and dyspnea on exertion improved and he gained 30 lbs. in weight. After 14 months the chest x-ray still showed a right midlung infiltrate that possibly contained a cavity and a left apical infiltrate with a cavity. The patient was therefore transferred to the Ohio Tuberculosis Hospital for evaluation and possibly surgery.

The patient denied any previous pulmonary symptoms. He had at no time experienced any hemoptysis. He had worked for 25 years as a cab driver and prior to that as a truck driver, and had had no known industrial or toxic exposure. He had smoked one to two packs of cigarettes per day for the past 30 years. He had no family history of tuberculosis.

Physical Examination

The patient was well developed, well nourished, and in no acute distress. The blood pressure was 130/78, pulse rate 88/min., respiratory rate 15/min. The chest had a slightly increased anteroposterior diameter with some increased resonance, normal expansion and excursion. The lungs were clear to auscultation. The heart was not enlarged and had a regular sinus rhythm; no murmurs or gallops were heard. No visceromegaly or masses could be palpated in the abdomen. The prostate was moderately enlarged, firm, and without nodules. No

Presented by

- R. D. Ruppert, M. D., Columbus, and
 - C. R. Macpherson, M. D., Columbus;
- Edited by Dr. Macpherson.

peripheral edema was noted. The findings on neurologic examination were within normal limits.

Laboratory Data

The laboratory findings at admission were within normal limits. Smears and cultures of the sputum from the time of admission produced no pathogens. Pulmonary function studies showed a maximum breathing capacity of 66 per cent; vital capacity of 110 per cent; forced expiratory volume at 1 second 50 per cent, 2 seconds 69 per cent, 3 seconds 80 per cent.

X-ray examination on admission showed a slow regression of the pulmonary disease bilaterally, with a large residual cavity in the left infraclavicular region measuring 3.5 cm. in diameter. Pulmonary emphysema was also suggested by low position of the diaphragm and multiple thin-walled lucent areas. A laminagram suggested a small radiolucent area in the right parahilar region most probably representing a filled-in cavity.

The electrocardiogram was essentially normal, with left axis deviation.

Hospital Course

After an initial evaluation it was decided that the patient should have surgical resection of the left apical cavity. On the 30th hospital day a left apical-posterior segmental resection was performed without difficulty. After surgery, marked subcutaneous emphysema developed. On the third post-operative day he noted some soreness in the left shoulder and arm, accompanied by marked shortness of breath and tachycardia. Examination at that time revealed a sinus tachycardia, rales in the

lung, neck vein distention, and a liver palpable 2 to 3 cm. below the costal margin. It was believed that the patient was in acute congestive failure and he was digitalized at that time. The cause for this episode of acute dyspnea was not established, but an acute myocardial infarction was considered a possibility. This diagnosis was not confirmed by electrocardiographic and enzyme studies.

On the eighth postoperative day it was noted that the patient had hyponatremia with serum sodium of 124 mEq./liter, potassium 4.5 mEq., chloride 81 mEq., CO₂ 28 mEq., blood urea nitrogen 7 mg./100 cc., and for the next two days he was treated with hypertonic saline. On the 22nd postoperative day he again had symptoms suggestive of an episode of acute pulmonary edema and at that time responded only moderately well to phlebotomy, digitalis, positive pressure oxygen, and diuretics. Shortly after this episode he passed some black, guaiac-positive stools and complained of some epigastric distress. An upper gastrointestinal x-ray series failed to reveal any ulcer or obstruction.

He continued to do only moderately well, had a very poor appetite and increasing weakness and lethargy. Six weeks postoperatively he again had an acute episode of shortness of breath with wheezing and generalized moist rales. He became diaphoretic with a drop in blood pressure, distended neck veins, firm nontender liver extending 4 finger-breadths below the costal margin, and no obvious edema. An electrocardiogram taken during this acute episode showed no changes from previous tracings. The patient was in profound shock and was transferred to University Hospital. He continued in profound shock, did not respond to massive doses of vasopressors, and died the following day.

CLINICAL DISCUSSION

DR. RUPPERT: I think I will not make any comment on the history here except on the one point that begins to prey upon my mind—this finding of severe dyspnea on exertion. We do not know how much lung disease he had back in his previous hospitalization, but when he was admitted here one does not see so much lung disease that he should have this much dyspnea on a pulmonary basis. His past history I think is really unremarkable except that he was a smoker.

The physical examination was completely within normal limits except for the finding that he did have increase in the a.-p. diameter and some increased resonance in the chest. In addition we also know he had tuberculosis. The remainder of the examination was normal, and this is very important. It is important that his liver was not palpable at this time, and the patient did not have the rales and the other findings that we hear about later. The pulmonary function studies showed a maximum breathing capacity of 66 per cent, vital capacity of

110 per cent, forced expiratory volume 50 per cent, 69 and 80 per cent at 1, 2, and 3 seconds. I think we can put this together and say that this patient did indeed have some type of obstructive lung disease. We might stop here and look at a sampling of his multiple x-rays.

Radiologist's Discussion

DR. DUNBAR: I agree that this is a moderately to severely emphysematous individual with the initial film showing inflammatory disease consistent with tuberculosis. This is our initial film, when there was a diffuse infiltrate in the left upper lobe and some parahilar infiltrate on the right. Fourteen months later, this has largely regressed. There is a large residual cavity in the left upper lobe and the laminagram did show some residual streaking around the right hilum but no definite cavitation. After surgery he had a rather persistent air leak—subcutaneous emphysema—never any significant pneumothorax, but the laterals did show even a month later some streaking here around the left lung. The final film is a portable one taken just before death. There are electrodes over the chest. I can't make a diagnosis of pulmonary edema, or infarction, or anything, really, on this film.

All along the heart has been small, as we see in an emphysematous patient. I don't think it changed appreciably. There is some haze along the right heart border that I would attribute mainly to fluid in the right major fissure. There could be some middle lobe disease but I don't really think it is significant. So I have no information about the cause of death whatsoever.

DR. BROWNING: Dr. Dunbar, aren't you concerned about the increase in the right base between the outside film and the one 14 months later? When we see a lesion clearing in most areas, a tuberculous lesion, and another area getting worse, we often question whether it is not a second diagnosis.

DR. DUNBAR: I have been looking at these laterals for about four days trying to make a diagnosis of carcinoma of the right middle lobe. I came finally to the conclusion that it was probably just pleural thickening in the major fissure.

DR. RUPPERT: I think the paucity of these x-ray findings is going to become a major factor in our diagnosis of what the actual cause of this patient's death was.

In the next paragraph there is a very important statement: "*The electrocardiogram was essentially normal, with left axis deviation.*" We are going to make a point of this throughout, so remember that he had left axis deviation and not right axis.

This patient then had surgery on his 30th hospital day—a resection. The next important thing is that on the third postoperative day he developed soreness in his left shoulder and arm accompanied

by shortness of breath, sinus tachycardia, rales in his lungs, neck vein distention, and now for the first time he had a palpable liver which was down 2 to 3 centimeters. What things would we consider? I am sure one of the most likely things would be pulmonary embolus. He did have EKGs and enzyme studies, all of which were normal. One can have, certainly, a pulmonary embolus and have a normal EKG or no change in the EKG, as well as no change in enzymes. The second possibility is acute myocardial infarction. This is also reported with normal EKGs and normal enzymes. The third possibility would be a pneumothorax, but the patient had x-rays repeated daily during this period.

Another possibility, I think, is an aortic aneurysm. Especially in the foreign literature today one sees that it is not very common but certainly not unknown to have a tuberculous arteritis. People have been presented with popliteal, femoral, abdominal, descending thoracic and ascending thoracic aneurysms, but I could not find a case where one had dissected backward along the ascending aorta.

Pericardial Disease

One of the things that I would like to bring up now and have you hold in mind is pericardial disease. It is true that people with chronic lung disease who do indeed have this long tear-shaped heart may well have heart failure and not demonstrate what we call an abnormally large heart. However, it seemed very strange to me that if this is true his axis deviation should have remained left. I would find this hard to believe unless this was a new acute process. We know he had tuberculosis for 14 months. Certainly in that period of time one could develop tuberculous pericarditis and begin fibrosing and scarring and constricting. At surgery they would see that this was not constrictive pericarditis, or markedly constrictive pericarditis. But this patient could well have had a fibrosing pericarditis, develop a small amount of effusion during this period, and indeed present with a constrictive type of lesion. From the University of Lyons it has been reported in some 100-odd cases of tuberculosis that a fair percentage of those patients that were resected developed pericarditis following a pneumonectomy.

Acute Adrenal Crisis?

On the eighth day postoperatively the patient had a sodium of 124, potassium of 4.5, chlorides of 81, HCO_3 of 22, and a BUN of 7. Could he have had an acute adrenal crisis? I think the fact that no one used steroids in this patient makes it highly unlikely. Dr. Hamwi, do you think he could get over an acute adrenal crisis without the use of steroids?

DR. HAMWI: The odds are pretty poor, but I think you are probably right. I have never seen an adrenal crisis with a BUN of 7. I think that's the giveaway.

DR. RUPPERT: On his 22nd hospital day this patient had a recurrence of his acute congestive heart failure. Now we see that he had *acute* pulmonary edema, and he responded moderately well to phlebotomy, digitalis, positive pressure, and diuretics. We have 19 days between the two episodes. There was no change in his chest x-ray. At this point one should see some changes in the electrocardiogram and other tests, but we do not.

Gastrointestinal Bleeding

The patient had a guaiac-positive stool. Why? One could suggest T.b. of the gastrointestinal tract. However, there has been a marked decrease in incidence under modern-day medical management. In the face of the drugs he was on, with negative cultures, this is unlikely. What else? It is obvious that this could be a stress ulcer. Why don't we see it on the x-ray? The classic thing would be to find several small hemorrhagic lesions of the stomach and these are superficial lesions, so it would not be surprising if one did not see it on x-ray. I would suggest that the positive stool guaiac is indeed possibly related to a stress ulcer and that the findings at autopsy may be minimal.

Then we see that the patient had a very poor appetite, increasing weakness and lethargy, and whatever this process is, it caused him to continue on in his downhill course. Then we proceed to a third episode of congestive heart failure, pulmonary edema, from which he did not respond and went on to die.

I assume that the patient did not bleed to death quietly and secretly. After three separate episodes I have been unable to incriminate the heart, pulmonary emboli, severe progressive lung disease, or persistent or recurrent pneumothorax. There are many other causes for congestive heart failure one could think about, but I'll put my neck on the block and say that I believe unequivocally that this patient had pericardial disease. He could have a myocarditis, a tuberculous myocarditis. I think this is unlikely. I cannot say absolutely and positively that he did not have a pulmonary embolus, myocardial infarction, etc., but I think it is unlikely in view of all the data that we have.

DR. BROWNING: May I ask what the working diagnosis was on transfer to University Hospital?

DR. THOMPSON: The working diagnosis was that the man had myocardial infarction. He went into severe shock and was transferred with a blood pressure of around 60/?, which it had been for a period of hours. He was sent over to the intensive care unit where one of the things we do is monitor. However, an EKG taken here at the time of transfer showed no changes.

DR. GREENBERGER: I think one of the interesting things to note is that shortly after he had this acute episode he was noted to have hyponatremia with a sodium of 124, but his BUN was only 7. The

presence of hyponatremia and a low BUN raises a question of inappropriate ADH [antidiuretic hormone] secretion, which by itself doesn't point you in any specific direction because it can be seen with tuberculosis, which this man had, with neoplasm, with cerebral disease, and a lot of other things.

CLINICAL DIAGNOSIS

1. Pulmonary tuberculosis with cavitation.
2. Surgical segmental resection, left upper lobe.
3. Postoperative emphysema (mild).
4. Constrictive pericarditis.
5. Stress ulceration of stomach.

PATHOLOGIC DIAGNOSIS

1. Pulmonary tuberculosis with severe cavitation.
2. Segmental resection, left upper lobe.
3. Poorly differentiated carcinoma of lung.
4. Neoplastic constrictive pericarditis and mediastinitis.
5. Direct infiltration of right atrium.
6. Ulceration of esophageal metastasis.

DISCUSSION OF PATHOLOGY

DR. MACPHERSON: I suspect that the Department of Medicine presented this case to demonstrate that even with the best of care and all available facilities there are certain diseases which can develop in a completely undetected fashion.

The cause of this man's death was pulmonary involvement and also involvement of the mediastinum and of the pericardium. There was a massive tumor infiltrate of the pericardium and mediastinum, of all the mediastinal nodes, of the entire right lower lobe, extending into the pleura, down through all of the lymph node chains, around the stomach into the porta hepatis. The entire liver was infiltrated. There were metastases in the pancreas, in the vertebral bone marrow, in the adrenal, and in the small intestine. The cause of death was probably mechanical embarrassment of the heart action and of the venous return due to this tumor infiltrate. I think it is obvious that this is undiagnosable, but at the same time Dr. Ruppert localized the trouble to the same area that we did.

The patient still had active tuberculous lesions in the right apex and in the right middle lobe, but all of these showed more fibrosis than extension and there were in each case a few areas of activity—small cavities—but nothing indicating that it was getting out of control. The cause of the guaiac-positive stool was carcinomatous infiltrate in the esophagus which had led to secondary ulceration and bleeding.

There was no evidence of any stress ulceration, and the metastasis in the small intestine was not such that it would have produced the bleeding. There was no evidence of thrombosis or embolization with the exception that one or two of the superficial epicardial vessels in the heart showed thrombi,

not related to areas of myocardial infarction. There was evidence of some emphysema in the lungs, but this was not the predominant problem and I don't think that it was functionally very important probably.

In essence then, we have tuberculosis in the left upper lobe, in the right upper lobe, and in the right middle lobe—all of it relatively inactive and responding well to therapy. We have a carcinoma of the entire right lower lobe with metastases spread very widely, primarily to mediastinum and pericardium. There was direct infiltration of the right atrium which was near the node, but there was no evidence anatomically that the SA node had been actually involved or infiltrated.

"Cigarette-Smoker's Carcinoma"

The other question then arises: Is this a carcinoma secondary to tuberculosis or is there some other etiology? In the cases where you get carcinoma following on tuberculosis, it's usually of the squamous type and is usually related to areas of fibrosis and metaplasia. In this case we have a rather typical cigarette-smoker's carcinoma. It's an oat-cell type of lesion with an occasional area of some squamous differentiation but it is not primarily a squamous type tumor. So I think we can say that the two lesions are probably coincidental rather than consequential.

The liver weighed 2,700 grams and this increase in size was due primarily to metastases.

This picture of the esophagus shows an ulcer with necrotic epithelium and small foci of tumor in the lymphatics, infiltrating deeply through the musculature. I think the ulceration was probably secondary to tumor infiltration.

This picture of the lung shows really the whole picture. Here is tuberculous scarring; here you have tumor infiltrating through the lymphatics; and here a rather subacute, and in some areas acute, bronchopneumonic process. There was a little bit of acute bronchopneumonia, but again this was a minor component rather than a major. You will notice that the tumor is not well differentiated; it shows no real sign of forming any particular pattern.

This liver nodule was about 2.5 centimeters in diameter and it does show some suggestion of a squamoid pattern. This was atypical. There were only a few nodules that showed any degree of differentiation at all. The adrenals did not show evidence of tuberculous involvement. Their combined weight was only 12 grams and there was only one microscopic focus of carcinoma.

In summary, therefore, we have a patient with a tuberculous lesion, which was treated and was under control, with coincidental development of a highly anaplastic and widely metastasizing carcinoma of the right lower lobe of the lung which I assume is not related to the tuberculosis.

DR. THOMPSON: I selected this case because I saw in the space of about five weeks three autopsies

reports of patients with varying stages of tuberculosis, under treatment, who all, incidentally, had widespread, very anaplastic carcinoma of the lung. They all showed some improvement as they were treated for their T.b. and then started going slowly downhill. These three carcinomas were all undiagnosed clinically. So I thought this would be an important subject to bring up for discussion. I think Dr. Ruppert did a very nice job in at least localizing the seat of the trouble.

DR. RUPPERT: I don't see how the surgeon could have done a left thoracotomy and pneumonectomy and not see tumor of the pericardium.

DR. MACPHERSON: Well, it was only segmental resection.

DR. RUPPERT: But I asked a thoracic surgeon about this, and they go down the arteries, they go

toward the hilum, and he said to not see the pericardium would be almost impossible.

DR. MACPHERSON: Yes, but I think the point is that this lesion started in the right lower lobe. It was almost a direct extension up from the right lower lobe and it would all be on the right side of the heart. I wouldn't be surprised if this tumor had doubled and redoubled several times in the space of six weeks. It is just growing wildly.

DR. HAMWI: I think Dr. Greenberger's point is one that should be kept in mind. With the abnormally low electrolytes and the preservation of renal function as far as the BUN is concerned, this almost eliminates the possibility of adrenal insufficiency, but with untoward ADH secretion there is usually a cause, and what this could have been might have tipped off a search for something else. This is in retrospect. It is so easy to go backwards and think these things over again.

SERUM ESTEROLYTIC ACTIVITY using the substrate benzoyl-L-arginine ethyl ester hydrochloride (BAEE) was studied in 202 patients with a wide variety of diseases, with particular reference to pancreatic and liver disease. There was considerable overlap of individual values for hospitalized patients with chronic diseases, patients with acute and chronic pancreatitis, patients with biliary-tract obstruction, patients with uremia and patients with carcinoma of the pancreas. However, patients with carcinoma of the pancreas and those with cirrhosis had the lowest levels of BAEE activity. The only group of patients clearly distinguished from the hospital control group were those with decompensated cirrhosis, who had the very lowest levels of BAEE activity.

Secretin and pancreozymin stimulation did not elevate the level of BAEE hydrolysis in the patient groups studied.

Measurement of serum esterolytic activity using the substrate BAEE is of no diagnostic value in patients with pancreatic disease.

Perhaps measurement of BAEE activity may have a role as a liver-function test. — Victor W. Groisser, M. D., et al., Jersey City, N. J.: *The New England Journal of Medicine*, 274:129-132, January 20, 1966.

NO SIN, READABILITY. — My plea is simply this: (1) If you have something to say, say it. (2) If you want your writings read, write readably. (3) Write English, not medicalese.

It is no sin to put your thoughts in simple terms and flowing phrases. And with today's proliferation of publications, it is the duty of everyone who dares add to it to do so briefly and clearly. — T. Stacy Lloyd, Jr., M. D., Fredericksburg, Va.: *Virginia Medical Monthly*, 94:73-74, February 1967.



NEWS AND *Organization Section*

Proceedings of The Council...

Policies Established on Certain Legislative Matters and Other Actions Taken at Meeting in Medina on March 18-19

A REGULAR MEETING of The Council of the Ohio State Medical Association was held at the Holiday Inn, Interstate 71 and Route 18, Medina, Ohio, March 18-19, 1967.

Those present on Saturday, March 18, were: All members of The Council except Dr. Frederick T. Merchant, Marion, Councilor of the Third District, and Dr. Oscar W. Clarke, Gallipolis, Councilor of the Ninth District. Others attending the meeting on Saturday were: Mr. Wayne E. Stichter, Toledo, OSMA legal counsel; Mr. David B. Weihaupt, Chicago, AMA Field Representative; Dr. John H. Budd, Cleveland, Chairman, Ohio delegation to the AMA; Dr. Robert E. Tschantz, Canton; Messrs. Page, Edgar, Gillen, Traphagan, Campbell, and Moore of the OSMA staff.

Those present on Sunday, March 19, were: All members of The Council except Dr. Oscar W. Clarke, Gallipolis, Councilor of the Ninth District. Others attending were: Dr. Arthur Collins, Cleveland, chairman of the OSMA Committee on Eye Care; Mr. James S. Imboden, Columbus, Field Representative, American Medical Political Action Committee; Dr. John Kernodle, Burlington, North Carolina; Mr. Wayne E. Stichter, Toledo, OSMA legal counsel; and Messrs. Page, Edgar, Gillen, Traphagan, Campbell, and Moore of the OSMA staff.

Dr. Meredith announced that Dr. Edwin R. Artman, Chillicothe, has notified the Association that he will be unable to attend the June meeting of the American Medical Association and is notifying his alternate delegate, Dr. Philip B. Hardyman, Columbus. Dr. Artman also indicated that he would attend the clinical meeting of the AMA in Houston in November; and that he would not be a candidate

for re-election to the AMA House of Delegates in May, 1967, for a two-year term beginning January 1, 1968.

Minutes Approved

Minutes of the meeting of The Council held February 18-19, 1967, were corrected to delete one paragraph in the report on Government Medical Care Plans and were approved.

Reports by Councilors

The Councilors reported on activities in their districts.

1967 Annual Meeting

Mr. Traphagan reported on developments concerning the 1967 Annual Meeting.

It was reported by the Executive Secretary that one candidate, Dr. T. L. Light, Dayton, Councilor from the Second District, has filed for the office of President-Elect under Chapter 5, Section 1(a) of the Bylaws regarding the nomination of President-Elect.

It was reported that 27 resolutions had been submitted for the consideration of the House of Delegates in May, 1967. They were distributed to The Council for information.

Hosts were assigned for distinguished guests who have been invited to the meeting.

Resolutions in Memoriam

The following resolutions were Approved by a standing vote:

GEORGE J. HAMWI, M. D.

George J. Hamwi, M.D., was our President during 1962-1963. He was more than just our President, however; he was our leader and our

inspiration for all that was accomplished that year by OSMA.

The hours that he spent as our Chief Executive were immeasurable and his devotion was undying. He was always willing — and even eager — to meet each new challenge. His closely-clipped mustache, his booming voice, his rapid step and his "welcome aboard" became familiar to all of those at the OSMA office. The personnel loved him — the staff respected him. They all worked for him because work became a real pleasure when George was at the helm.

It has been stated that George was a religious man — not on the surface — but deep down where it counts. He respected his fellow men — and this respect was mutual.

Yes — George Hamwi will be missed by all who knew him. However, he did not live in vain. His contributions to the Ohio State Medical Association, to the medical school and its students, to Medicine and the field of Research and to his community will live forever.

At the funeral, the Minister stated that "George did not believe in Death" — so let's remember this above all else.

CARL S. MUNDY, M. D.

After a full life of 77 years, Carl S. Mundy, M. D., passed away on February 6, 1967, following a brief illness. Dr. Mundy's life is a remarkable example of unselfish devotion to duty, both as a physician and as a citizen.

As a physician, Carl Mundy served his community as a pioneer in the practice of internal medicine. He served medicine in many positions, among which were: chief of staff of Maumee Valley Hospital, Toledo; president of the Toledo Academy of Medicine; Councilor of the OSMA Fourth District; and president of Ohio Medical Indemnity, Inc.

As a citizen, Carl Mundy took an active part in election and community endeavors. He was an enthusiastic sailor, having been founder and first commander of the West Lake Erie Cruise Association.

No finer epitaph could honor him than one which says: Here lies a devoted citizen and physician.

County Societies

Cuyahoga County — Dues for Drs. Evelyn Gomb, Lucia C. Trandafir, and Ellen N. Rothchild were reduced to \$15.00 under provisions of Section 1, Chapter 2 of the Bylaws.

Stark County — A proposed amendment to the Stark County Medical Society constitution and bylaws, which would, in effect, increase the membership of the council of that society by adding the delegates elected by the membership and any member of the society while holding elective office in the OSMA.

The Council approved the proposed amendment and instructed the Executive Secretary to so notify the Stark County Medical Society.

Ohio Department of Public Welfare

A proposed billing procedure submitted by the Ohio Department of Public Welfare was considered. By official action, The Council requested the Ohio Department of Public Welfare not to implement the proposed billing form at this time, but that Mr. John W. Main, chief, Division of Administrative Services, meet with The Council to clarify the proposal and to interpret material on the proposed billing card. The Executive Secretary was instructed to address a communication to the Honorable Denver White, asking that he and Mr. Robert Canary, Assistant Director, meet with the officers of the Ohio State Medical Association to discuss the restoration of funds necessary to permit payment of 100 per cent of the usual and customary fee in the welfare budget.

Presented for Council consideration was a letter from Director White dated March 13, 1967 and a letter of March 3, 1967, from the President to Director White. The Council adopted the following statement with regard to the obligation of the Department of Public Welfare

On July 23-24, 1966, The Council entered into a temporary agreement with the Ohio Department of Public Welfare whereby:

1. Members of this Association would submit bills for their full usual, customary, and reasonable fees and the Department would reimburse them for their professional medical services in the amount of 60 per cent of their full fees, and

2. The Department would actively solicit and this Association actively support in the Ohio General Assembly the appropriation of funds adequate to pay the full usual, customary, and reasonable fee a physician charges for his professional services.

In recent weeks the executive budget has been submitted to the General Assembly. Despite repeated efforts and a formal letter to the Welfare Director attempting to determine if the Department so requested the funds necessary to provide full payment, the Department has consistently declined to answer our questions or to state if the necessary funds are contemplated in the proposed executive budget.

This Council notes with serious concern the forthcoming legislative hearings on the budget. Council wishes to point out that the Association and its members cannot effectively and realistically support and work for appropriations which the Department either will not or cannot identify as a part of the Department's proposed budget.

Therefore, it is the decision of The Council that, unless the requested and vitally necessary information is provided by the Department with-

out delay, Council has no choice but to rescind the agreement made in 1966.

Further, Council has no choice but to advise members of the Association that the Department has not fulfilled its part of the agreement, and that members should establish their individual policies regarding treatment of welfare patients accordingly.

Council would further emphasize that the anticipated expansion of Title XIX programs, the Social Security health payment program, and other government programs threaten the membership with an ultimate situation whereby a considerable majority and, eventually, all of their patients could be covered by government medicine.

Council also would emphasize that when government accepts the responsibility to reimburse certain segments of the population for their medical expenses, then government must live up to the obligation it has assumed. Otherwise, the medical profession is being forced to pay a double subsidy for such programs—through direct and indirect taxation as one subsidy and the forced fixed and reduced fee schedules as another.

The medical profession and quality medical care for all segments of the population cannot survive under such conditions, nor can medicine be expected to attract into the profession the manpower necessary to provide such care.

State Legislation

Mr. Page and Mr. Traphagan presented for the consideration of The Council a number of proposals which have been introduced, or will be introduced, in the Ohio General Assembly.

Dr. Arthur D. Collins, Cleveland, discussed Senate Bill 173.

By official action, The Council adopted policies with regard to the following measures:

S. B. 17, (Carney), to remove relatives' liability for support of patients in mental hospitals or benevolent institutions under the control of the department of mental hygiene and correction. (active opposition)

S. B. 31, (Calabrese), to create Air Pollution Control Board. (approve principle)

Am. S. B. 32, (Weisenborn), to provide for the examination of persons suspected of having tuberculosis. (active support)

S. B. 58, (Collins-Jackson), relative to the authority of trustees of tuberculosis hospitals. (no position)

S. B. 60, (Carney), relative to regulating the identity and quantity of commodities packaged in advance of sale at retail. (oppose in present form)

S. B. 69, (Armstrong-Sullivan), relative to the power of injunction by the state board of optometry. (no position)

Am. S. B. 74, (Weisenborn), to control the manufacture, possession, distribution, and sale of LSD and drugs having similar hallucinatory effect. (support)

S. B. 78, (Powell - Aronoff - Turner), to provide that permanently disabled electors may obtain from their physicians and file with boards of elections a certificate of such permanent disability, which certificate shall support their applications for disabled voter's ballots for a period of five calendar years. (approve principle)

S. B. 106, (Carney), relative to providing medical assistance to certain needy persons who are unable to meet the cost of necessary medical care. (oppose)

S. B. 107, (Nye-Ocasek), to create a medical school at the University of Akron. (no position—support new school)

S. B. 151, (Dennis), to provide penalties for the violation of orders of the Director of Health or regulations of the Public Health Council. (needs further study)

S. B. 155, (Taft), relative to the registration of births and the certification of birth certificates. (support)

S. B. 169, (Armstrong-Holcomb-Weisenborn), to provide for the creation of a county board of mental retardation and to define its powers and duties. (oppose)

S. B. 173, (Guyer-Armstrong), relative to optometry and the freedom of choice in utilizing professional services. (active opposition)

S. B. 126, (Guyer-Collins), relative to the membership of a board of trustees of a hospital service association. (no position)

H. B. 15, (Norris), makes recommitment of mentally ill person procedure the same as commitment procedure. (approve)

H. B. 96, (Lancione, et al.), to provide for control of possession and distribution of LSD and drugs having a similar effect. (object in present form)

H. B. 103, (Wetzel, et al.), to provide for an Ohio - West Virginia interstate compact to control air pollution. (approve principle)

H. B. 106, as amended, (Weis-Nixon), to provide for the licensing of hearing aid dealers. (approve principle, do not approve specific bill unless amended to satisfy OSMA; include physician on board)

Sub. H. B. 111, (Mastics, Cadwallader, Sweeney and Rentschler), to control manufacture, sale, and possession of LSD and drugs having similar hallucinatory effect. Substitute bill to be introduced; will include marijuana in separate hallucinatory drug statute. (support)

H. B. 119, (Hale), to require inclusion of family living course in high school curriculum. (approve)

H. B. 172, (Fry-Fisher-Stocksdale), to require use of slow-moving vehicle emblems both day and night rather than night only. (approve)

H. B. 178, (Galbraith-Quilter), to provide for the establishment of a bureau of mental retardation

within the division of mental hygiene. (support actively if amended to provide for physician head of bureau)

H. B. 215, (Stokes), to establish the right of a living person to control and direct the disposition of his body or any part thereof after death. (active support)

H. B. 269, (Voinovich-Tulley-Bartunek), to permit admission of evidence on amount of alcohol in traffic violator's blood; establishes 0.1 per cent as prima facie that he was under the influence; if he so requests, test to be done by physician of his choice. (support)

H. B. 292, (Manning-Pemberton-Mills), to provide for payment of hospitalization of indigent persons injured in motor vehicle accidents. (needs further study)

H. B. 294, (McNamara-Norris), to raise renewal registration fees of registered optometrists. (no position)

H. B. 312, (Mottl), to prohibit medical quackery. (support if properly amended)

H. B. 314, (Albritton, et al.), relative to water pollution control. (approve principle)

H. B. 318, (McNamara, Netzley), to require the director of the department of public welfare to determine what payments to welfare recipients shall be treated as income. (no position)

H. B. 360, (Kohnen, et al.), Nurse Licensure. (active opposition)

H. B. 387, (Fry) makes confidential the records of medical research projects of hospitals reporting to State Health Department on mortality reduction. (active support; substitute bill)

H. B. 344, (Jones), to eliminate requirement that physician performing premarital serology have Ohio license. (no objection)

H. B. 408, (Galbraith), to modify State abortion laws. (active support with amendment)

H. B. 418, (McNamara), medical practice act revisions. (active support)

H. B. 419, (Kerns) sets standards for blood alcohol contents in drunk driving cases. (needs further study)

H. B. 434, (Norris), to require physician's certification, or his statement of the person's refusal to be examined, before hospitalization of a mentally ill person. (needs further study)

H. B. 445, (Thorpe-Reichel), to restrict the use of experimental drugs in human investigation. (active support)

A mandatory bill for licensed practical nurses was submitted. The Council voted to actively oppose the bill if introduced.

The Council discussed a bill to provide for waiver of physician-patient privilege in certain cases upon the commencement of an action when a civil law suit

is brought. It was the decision of The Council that this bill needs further study.

Appalachia

Dr. Tschantz reported to The Council with regard to a meeting on Appalachia held March 5, 1967, at Lake White and another meeting held March 10, 1967, in Washington, D. C.

Presented to The Council were communications from Dr. George Newton Spears, Ironton, dated March 6, 1967, and Dr. Richard E. Bullock, McArthur, dated March 13, 1967.

Subsequent to consideration of the above material and other information, The Council adopted the following Statement of Policy on Appalachia and Other Government Health Programs:

Appalachia and Other Government Health Programs

The Council of the Ohio State Medical Association recognizes the responsibilities of members of the medical profession as a central factor in providing adequate medical and health care to all segments of the population.

Any program or efforts to provide such care should be designed to augment and complement the availability of sound medical and health care in a given community. The plan defeats its purpose and creates a negative community situation if it uproots, disrupts, or brings about termination of existing services and facilities.

To that end, constructive criticism never should be misinterpreted or misrepresented as unfeeling opposition or obstruction, but rather as a method of achieving an improved and equitable condition that best serves the interests of the community's residents.

It must be emphasized that any program must take medical and health care to the people, rather than remove it from easy accessibility.

Whether any proposed project be multicomunity or multicounty, in order to achieve positive goals, the planning, establishment, and development of the project must be carried out according to the following concepts.

1. The medical profession of each community in the overall area must be initially, permanently, and effectively involved from the beginning and on a policy-making level as voting members.

2. The health care needs of each community must be clearly established, and it must be determined that the needs established are realistic.

3. Rather than expend large sums of money for the construction of larger demonstration health centers, adequate funds should be made available for the addition to and enhancement of local facilities already in operation. These facilities may be single or multicounty.

4. Evidence must be submitted to the OSM

Council that an honest attempt has been made to utilize and coordinate all local resources, private, voluntary, and public health before government assistance is requested.

5. The creation or expansion of a core facility shall in no way be binding upon a physician to refer his patient to that facility.

6. The operation of any regional or county health service center shall not infringe upon the private practice of medicine.

7. The use of welfare and other government funds as regards patient and health care should be based on helping those who need help by providing them with funds to pay for the medical and health services they require.

8. These projects shall in no way be developed, operated or influenced in a manner which could lead to a government controlled system of medical practice.

Harrison County Proposal

The Council voted to oppose strongly the use of funds from the Appalachia program for the contemplated Harrison County project for the following reasons:

1. The size of the community does not warrant this type of structure.

2. With the number of physicians available, it is impossible to maintain this type of structure.

3. This type of structure was not originally approved by the County Medical Society.

4. This structure of community health center will never be self-supporting.

Opportunity Education Project in Belmont County

A proposed Opportunity Education Project in Belmont County was discussed. The President of the Ohio State Medical Association was asked to direct letters to Senator Frank J. Lausche and Representatives Frank T. Bow, Michael J. Kirwan, William E. Minshall and Wayne L. Hays, calling attention to the action of the Community Action Committee of Belmont County and including a copy of the proposal of that committee.

Federal Legislation

Mr. Edgar reported that hearings on H. R. 5710 were temporarily suspended and that it is indicated that Dr. Hudson will testify for the AMA on April 4, 1967. Mr. Edgar stated that the Ohio State Medical Association will prepare a statement for every member of the House Ways and Means Committee and for all Ohio Congressmen. County Medical Societies will be encouraged to write to the congressmen in their districts. The Council received for its information tax structure contemplated by the Social Security Administration for succeeding years with or

without the passage of H.R. 5710 and information was presented indicating that the United States Chamber of Commerce will assist the American Medical Association in opposing this measure.

Mr. Edgar informed The Council that a list of Federal health bills is being completed to accompany the legislative bulletin.

Ohio Medical Indemnity, Inc.

The Executive Secretary reported for the Liaison Committee of Ohio Medical Indemnity, Inc.

Dr. Smith, as chairman, presented a report of the nominating committee appointed by the President submit the names of candidates for the Board of Directors of Ohio Medical Indemnity, Inc. The committee recommended that the following be nominated and elected for the ensuing year: Ralph L. Abernathy, Dayton; Dwight L. Becker, M.D., Lima; William T. Blair, Columbus; J. Martin Byers, M.D., Greenfield; Nino M. Camardese, M.D., Norwalk; H. M. Clodfelter, M.D., Columbus; Clair E. Fultz, Columbus; Lloyd E. Larrick, M.D., Cincinnati; Robert S. Martin, M.D., Zanesville; J. A. Meckstroth, Columbus; Howard C. Sauer, Canton; Frank L. Shively, M.D., Dayton; Harold W. Slabaugh, Akron; Msgr. John C. Staunton, Cincinnati; Gordon M. Todd, M.D., Toledo; William A. White, M.D., Canton; Francis M. Wistert, Toledo; Edmond K. Yantes, M.D., Wilmington; Starling C. Yinger, M.D., Springfield; John R. Meek, M.D., Cincinnati; M. M. Thompson, M.D., Toledo.

By official action, The Council approved the nominations presented and authorized the following to cast the votes of the Ohio State Medical Association, a stockholder, at the annual stockholders' meeting of OMI in April on all business matters coming before that meeting, including the election of directors placed in nomination by The Council at this meeting on March 18-19, 1967: Dr. H. M. Clodfelter, Columbus, or Dr. Edmond K. Yantes, Wilmington, or Mr. Hart F. Page, Columbus.

Workmen's Compensation

Mr. Campbell reported on workmen's compensation developments. It was the decision of Council that a communication be directed to the Summit County Medical Society explaining our position with regard to the usual and customary fee in connection with workmen's compensation and asking the cooperation of the society in this program.

Ohio Society of Internal Medicine

The Council considered a communication from the Ohio Society of Internal Medicine requesting a column in *The Ohio State Medical Journal*. It was the expression of The Council that scientific information in the field of internal medicine would be most acceptable for publication in *The Journal*; but with reference to socio-economic articles, acceptance would not be in order since the OSMJ is the

official organ of the Ohio State Medical Association and it would be confusing to the members if socio-economic policies of the various specialty and sub-specialty organizations were contained in the same publication.

Committee Reports

Cancer Coordinating Committee

Mr. Traphagan reported on a meeting of the Cancer Coordinating Committee held January 26, 1967. The minutes included a report on the Ohio Tumor Registry Survey. The minutes were accepted for information.

Hospital Relations

The minutes of the meeting of the Committee on Hospital Relations held January 8, 1967 were presented by Mr. Gillen. With regard to the recommendations of the Committee on hospital licensure, The Council did not approve the recommendations of the Committee but referred the entire matter back to the Committee for further study.

The Council approved the expenditure of \$100.00 to send the booklet entitled "Emergency Department—A Handbook for Medical Staff," published by the AMA, to Ohio hospital chiefs of staffs.

The Council approved, as well, the recommendation that a publication of the Summit County Medical Society entitled "Contract Practice in Emergency Rooms—A State of Policy" be sent to all Ohio hospital chiefs of staffs, contingent on approval of the OSMA legal counsel.

The remainder of the report was approved as presented.

Mr. Gillen then presented the minutes of the meeting of the Committee on Hospital Relations held March 12, 1967. These minutes dealt with a proposed hospital licensure bill developed by the Ohio Department of Health. The Council recommended that this matter be referred back to the Committee on Hospital Relations for further study.

Mental Health

Minutes of the meeting of the Committee on Mental Health held January 8, 1967 were presented by Mr. Traphagan. Council approved the recommendations of the Committee with regard to an educational campaign on LSD and the sponsorship of four regional postgraduate meetings in the Fall of 1967 on the subject "The Many Faces of Depression." Also approved was a \$200.00 appropriation for an exhibit on "Hospitalization of the Mentally Ill in Ohio."

The Council approved, with several amendments, the Committee's recommendation with regard to legislation to establish a regulatory Board of Mental Health and Correction. The amendments had to do with the composition of the proposed board and they are as follows:

- A. Three physicians with demonstrated knowledge and interest in mental health.
- B. One person with demonstrated knowledge and interest in mental health.
- C. Two physicians with demonstrated knowledge and interest in mental retardation.
- D. Two persons with demonstrated knowledge and interest in mental retardation.
- E. Three persons who hold the degree Master of Arts in Corrections or Masters in Social Work or an equivalent degree.
- F. One physician with demonstrated knowledge and interest in the field of psychiatric criminology.

Also approved was a bill to establish statutory autonomy for mental retardation at the division level.

The Council received information on the Ohio Psychiatric Association Colloquium on the Community Mental Health Act on March 5, 1967.

Disaster Medical Care

Mr. Campbell presented the minutes of the meeting of the Committee on Disaster Medical Care on January 22, 1967. The Council approved the Committee's recommendation that the Ohio State Medical Association endorse, participate in, and cooperate with the Governor's Office of Emergency Planning Health Resource Task Group on matters concerning the medical profession.

The Council returned to the Committee for the delineation of scope and expense a recommendation that each OSMA Disaster Medical Care District hold a total of two meetings this year.

The remainder of the report was approved as presented

Health Resource Task Group

The minutes of the meeting of the Health Resource Task Group on February 15, 1967 were received for information.

Maternal Health

Mr. Gillen presented the minutes of the meeting of the Committee on Maternal Health held January 21 and 22, 1967. The Council approved the recommendations of the Committee with regard to the Rubella Control Investigation Project as follows:

1. That the OSMA go on record as favoring a voluntary 'Rubella Control Investigation Project';
2. Recommended to The Council that the Committee on Laboratory Medicine outline a program whereby selected laboratories throughout Ohio make the test available; and
3. Recommended for the Committee on Maternal Health coordinate efforts with the Committee

(Continued on Page 663)

(Continued from Page 654)

on Laboratory Medicine to develop a program of implementation as soon as practicable.

The Council also approved the Committee's recommendation that legislation be developed to protect the Ohio mortality study.

Laboratory Medicine

Mr. Campbell presented the minutes of a meeting of the Committee on Laboratory Medicine held on Wednesday, March 15, 1967, which included the draft of a proposed bill on laboratory licensure. After considerable discussion of the minutes and of the legislative draft. The Council postponed a decision pending further study of the matter.

National League for Nursing Recommendations

The following was adopted concerning the National League for Nursing:

"That the OSMA Council communicate to the National League for Nursing its concern of the untimely closing of Diploma Schools of Nursing and urge the League to make every effort to retain and expand all NLN accredited programs in nursing."

Mr. Gillen was authorized to present this information at the forthcoming meeting of the National League for Nursing.

County Society Officers Conference

Mr. Edgar reported on the 1967 County Society Officers Conference held February 26. He suggested that the timing of the conference probably could be improved.

The President appointed the following committee to consider this suggested proposal: Dr. Robert E. Howard, Cincinnati, chairman; Dr. Richard L. Fulton, Columbus; Dr. Robert N. Smith, Toledo, and Dr. William R. Schultz, Wooster.

AMA Socio-Economic Conference

Drs. Meredith and Tschantz and Mr. Edgar reported on the First National Congress on Socio-Economics of Health Care held in Chicago, January 22-23, 1967. The Council voted to communicate with the American Medical Association its dissatisfaction with the content and conduct of this conference.

Meetings

The Council received reports on the AMA Medico-Legal Conference on Rural Health, March 9-11; Ohio Hospitalization Benefits Committee, March 1; and the SMJAB Program Planning Committee, March 4.

Student Health Services

A complaint about student health services at an Ohio college was referred to the Committee on School Health for study, along with a question from The Council on physical examination forms for college admission.

Orthopaedic Training Programs

A communication from Dr. James G. Roberts, Akron, regarding a program to study and re-evaluate orthopaedic care and orthopaedic training programs throughout the State of Ohio was considered. The Council offered the cooperation of the OSMA to the degree relevant and referred the matter to the Committee on Education for study.

Correspondence Between AMA and OSMA Presidents

A motion was made to reconsider the February 18-19 Council action ordering publication of correspondence between the Presidents of the AMA and the OSMA. The motion prevailed. The Council then adopted a motion to publish the original letters without amendment.

Woman's Auxiliary Bylaws

Proposed amendments to the Bylaws of the Woman's Auxiliary were submitted along with a letter from Mrs. Fred Rittenger dated February 13, 1967. The expression of The Council was that there are no legal objections to the amendments.

OSSMA Bylaws and Amendments

The Council received the proposed amendments to the Bylaws of the Ohio Society of Medical Assistants and it was The Council's expression that there are no legal objections to such amendments.

Opinion on Review of Fees

The Council amended its policy on review of fees as adopted February 18-19, 1967 to read as follows:

"It is proper for the physician to establish the fee which he charges to any patient for the professional service rendered, with recognition of the fact that a duly constituted County Medical Society committee of his peers may appropriately review and pass upon the equity and justice of his charge. It is not proper for hospital management nor a hospital medical staff, nor any insurer, nor any hospital service association to attempt to exercise this function.

"Neither the hospital management nor the hospital medical staff, nor any insurer, nor any hospital service association has the privilege or the right to demand an audit of staff members' personal financial records for any purpose. Any such attempt on the part of the medical staff to compel such audit is unethical."

The Executive Secretary was instructed to incorporate this policy in a communication to Mr. Vernon R. Burt, Executive Director of Northeast Ohio Blue Cross.

Blue Cross

Payments to Residents and Interns

The problem created by the number of Blue Cross hospital insurance to residents and interns and other

related persons was referred to the Committee on Hospital Relations.

AMA Disability Program

The AMA Disability insurance program was discussed. The Council subsequently adopted the following recommendation:

1. That the Board of Trustees of the American Medical Association to give further consideration to the Fireman's Fund American Life Insurance Program offer to underwrite the AMA Disability Insurance Program without change in existing premium and benefit structure.

2. If the Board of Trustees is still of the opinion that the AMA should continue the Continental Casualty program with the modifications and revisions in premiums and benefits, then it should defer executing the contract at this time and submit the recommendation to the House of Delegates at the June meeting.

It was directed that a copy of the statement be forwarded to the American Medical Association.

Title XIX Advisory Committee

The Executive Secretary was instructed to communicate with Dr. John R. Kernodle, Burlington, North Carolina, to suggest the following Ohio physician for membership on the Advisory Committee to Title XIX: Carl G. Madsen, Jr., M.D., Painesville; Robert E. Tschantz, M.D., Canton; or H. William Porterfield, M.D., Columbus.

Miscellaneous

A communication from Dr. Leonard B. Green-tree, Columbus, was referred to the Committee on Education.

A communication from Mr. Frank E. Kunkel, Executive Secretary of the State Board of Pharmacy, with regard to a request from the Brewer Pharmacal Engineering Corporation to permit the use of Brewer equipment for dispensing drugs in Ohio hospitals was referred to the Committee on Public Relations and Economics.

Commendations

The Council, by a rising vote, expressed appreciation and commendation to Dr. Meredith for his devotion, his leadership, and his judgment during the past year as President of the Ohio State Medical Association and as presiding officer of The Council.

The Council adopted a resolution expressing thanks to Drs. Crawford, Hardyman, and Beardsley for their diligent attention to duty and able representation of their constituents as their terms of office on The Council come to a close.

There being no further business, The Council adjourned.

Attest: HART F. PAGE,
Executive Secretary

Pediatrician Researchers To Meet In Columbus, October 26-27

There is a change of date for the fall meeting of the Midwest Society for Pediatric Research.

The new dates are October 26 and 27, 1967, in Columbus, Ohio. (An earlier announcement set the dates as October 31 and November 1.)

The scientific program will be jointly planned by the Ohio State University College of Medicine, Department of Pediatrics, and Children's Hospital in Columbus.

Contact: W. A. Newton, Jr., M.D., Children's Hospital, 561 South 17th St., Columbus, Ohio.

American College of Physicians Schedules Cincinnati Course

The American College of Physicians will present one of its regional postgraduate courses in Ohio in June.

"Internal Medicine: Current Physiological Concepts in Diagnosis and Treatment," is the topic for a program to be presented in cooperation with the University of Cincinnati College of Medicine, June 12-16. Dr. Richard W. Vilter, director of the Department of Medicine, is director of the course.

Other postgraduate courses offered by ACP include the following:

"Clinical Auscultation of the Heart," Georgetown University School of Medicine, Washington, D. C., May 8-12.

"Recent Advances in Clinical Endocrinology," University of Washington, Seattle, May 15-19.

"Clinical Applications and Recent Advances in Electrophysiology of the Heart," New York University School of Medicine, May 22-26.

"Clinical Applications and Recent Advances in Pharmacology," University of Iowa, June 19-21.

Dr. William F. Boukalik, past president of the Academy of Medicine of Cleveland, was speaker for the Wayne County Cancer Crusade kick-off luncheon in Wooster.

Dr. William H. Cope, recently appointed acting director of the Division of Physician Manpower, U. S. Public Health Service Bureau of Health Manpower, is a native of Ohio and graduate of Ohio State University College of Medicine.

The American College of Gastroenterology, in cooperation with William H. Rorer, Inc., of Fort Washington, Pa., has announced the 1967 Rorer Award Contest for papers in gastroenterology. Details may be obtained from the organization's headquarters, 33 West 60th Street, New York, N. Y. 10023.

Correspondence Between OSMA President And President of the AMA

THE FOLLOWING CORRESPONDENCE between the President of the Ohio State Medical Association and the President of the American Medical Association is published at the direction of The Council, in keeping with action taken at a meeting on March 18-19:

January 27, 1967

Charles Hudson, M. D., President
The American Medical Association
Cleveland Clinic
2020 East 93rd Street
Cleveland, Ohio

Dear Charlie:

Many Ohio Newspapers carried Washington Associated Press release of interview with you at the Regional Programs Planning Conference held in Washington Sunday January 15-17. Subsequent to this interview generally titled *Doctors Accept Medicare*, I have received numerous letters from Ohio Physicians protesting the comments quoted in the interview.

I would be less than fair to these physicians if I failed to quote some of them: "Naturally, I am not objecting to Dr. Hudson every day and so I presume he actually is hearing less objections." "His statement is, in my opinion a shocking betrayal of his office." . . . "I read with great dismay that our AMA President, Dr. Charles Hudson released an ill informed statement to the press to the effect that the doctors felt Medicare was fine and they were experiencing no difficulties with it." . . . and on.

From a less emotional point of view I see this interview a fine attempt on the part of the press to quote out of context.

The article reads two ways:

A. To Accept:

1. Few objections.
2. Fewer rebellious members.
3. Not a monster.
4. Medicare not now intangible.
5. Difficulties will disappear in time.
6. Direct billing merely continues a tradition.

B. Not To Accept:

1. "Yet Hudson emphasized the medical profession is far from happy with Medicare."
2. "Many doctors are really hot under the collar" about a certification form.
3. AMA plans to seek elimination of the provision by an amendment of the law.
4. "We would abhor a National Health Plan."

5. Doctors generally still object to the idea of using tax money to provide medical care for those of the elderly who can afford to pay.
6. "He said that doctors exercise their option to bill their patients directly rather than billing the Government Insurance Carrier."

There is great distress among Ohio Physicians. I am enjoined to ask for clarification. I must reply to my members. I must refute the statement concerning general happiness of the profession with Medicare.

I would greatly appreciate a statement from you which could be used to offset the discontent and criticism which daily seems to be growing in volume.

Sincerely,

LAWRENCE C. MEREDITH, M.D.
President
Ohio State Medical Association

February 3, 1967

Dr. Lawrence C. Meredith
President
Ohio State Medical Association
205 Elyria Block
Elyria, Ohio 44035

Dear Larry:

Not only at your request but at my own wish, I should like to respond to your letter of January 27, 1967. I will say at the outset that the report was poorly written and unfaithful to the interview which lasted about 30 minutes, and by overemphasis and underemphasis selectively, the report and especially the headlines created a false impression. I regret the anguish it may have caused some of my colleagues, but I am amazed that a few have so little confidence in me and so little understanding of the ways of newspaper reporters and headline writers.

There was little reaction to the report. Before I received your letter, I had three from Ohio, one from Missouri, one from the State of Washington and one from Indiana.

This letter will provide answers to some of the questions in your letter, and will at the same time help me assemble the ideas that I always include in answering the inevitable question: "How is Medicare going?" It may be useful to anyone who now questions what his objections to Medicare are, how fundamental they are, and how presentable such objections might be to a public that, according to a Harris poll is toying with the idea of a medicare-type program for for everyone.

To restrict a trend toward a complete national health service, or contain it, or to repeal some of the present statutes, an appeal must be made to the public, to dissuade them from seeking a federal system of medical care. In other words, they must be shown that the model of health care they now desire so badly is not what they will receive if a national system should be put into effect. The quality of that service as it has been evolved largely by the private sector will not be there under a federal system. Therefore, in order to avoid omissions, I always follow a mental outline which discusses:

1. The Long-range Consequences of the Present Medicare System. After many years without success, the proponents of Social Insurance persuaded Congress to incorporate it in Title XVIII of the Social Security Amendments of 1965. It permits the government to tax one group of individuals to provide health services for an entirely different group, regardless of the fact that the beneficiaries may be well able to provide for themselves. There is no determination of financial need as has been true of past welfare measures. Some characteristics of this measure are not exactly germane to the subject of health care: that it is unfair, it is regressive and individuals who might think it unsuited to their particular needs are, in effect, deprived of the right to select an insurance program of their own choosing.

More importantly, it would lead through a number of intermediate steps and necessary amendments of the law, to a deterioration of the quality of medical care which is our prime concern. Expansion to include other individuals by including other categories of people or depressing the age limit could be accomplished until ultimately it might include everyone in the population.

Furthermore, the provision of a "free" program develops a sense of entitlement by the public and reduces their incentive to contribute to the cost of their own care. Ultimately, in a national system where all funds come from the federal treasury, health must compete with other programs for the federal dollars. It might well be then that funds for health would be curtailed and the amount for health determined by individuals who had no interest or knowledge in health affairs. Restrictions and controls and probably new methods for reimbursement of health personnel would be instituted, producing ultimately an unsatisfactory working situation for personnel and a poor quality of health services. The situation would further deteriorate by impoverishment of facilities, failure to attract new personnel to the system and emigration of those already in the system. This sequence of events is observable abroad and lessons can be learned from these observations.

2. Short-range Considerations. These are of two varieties: first, those directly concerned with the freedom of the physician to practice medicine at his best; and second, factors more of an administrative nature

which may indirectly inhibit the physician in the care of his patients.

Regarding the first category in response to direct questions, I have said that I do not know of instances where those provided with authority by law, namely the state agent and the carrier, have interfered with a physician's professional judgment. This is merely a statement of fact.

In the second category, of administrative detail, I have mentioned that there are severe difficulties, resulting in delay in payment of patients' claims and confusion in dealing with deductibles, co-insurance, reasonable charges and so on. While it is true that these items can indirectly affect the physician in the care of his patients, they are matters that undoubtedly will be clarified administratively.

My impressions of Medicare, therefore, must be viewed from both the short-range and the long-range viewpoints. Considered as a whole, there is no opportunity to say that I believe physicians no longer oppose Medicare. If there should be an impression of acceptance, it would be in my saying that physicians have been caring for their elderly patients without direct interference.

While we expect administrative problems to lessen, we continue to search for evidence of expansion of Title XVIII or XIX. You may depend upon it that the AMA and I will do our best through legal channels and by appealing to the public and their legislators, to keep the influence of the federal government to a minimum.

Sincerely yours,
CHARLES L. HUDSON, M. D., President
American Medical Association

February 10, 1967

Charles L. Hudson, M. D., President
The American Medical Association
Cleveland Clinic
2020 East 93rd Street
Cleveland, Ohio

Dear Charlie:

Thank you for your quick response to my letter. I am sorry not to have been available when you called. I was (January 31, 1967) at the Harbor Hill Country Club in Licking County attending a dinner for the Honorable John Ashbrook.

I am well in accord with the text of your reply. However, I do not agree with your conclusions concerning administrative clarification of problems which are currently plaguing SSA area carrier, physicians, and recipients of Medicare. Many such areas of discontent are of technical administrative in nature, to be sure, such as failure to reimburse physicians who have and are quite willing to accept assignment and areas where either patient has inaccurately or insufficiently filled out 1490 forms. My disagreement with your

evaluation arises from a distinct feeling that in areas of conflict between the ultimate ease of processing direct billing that certain administrative solutions can be made which would place such procedure in jeopardy.

Our organization's must not be complacent in the presumed right of HEW or SSA to evolve administrative solutions. It most certainly can be shown that from an actuarial point of view, direct billing is difficult to process, fraught with delay, and is more costly. Hence, a most valid recommendation could be made that the direct billing option must be withdrawn even at the risk of arousing the ire of the physicians.

In addition the profession could well be snared into an untenable and paradoxical position by opposing the economy suggested by the assignment method since the AMA long opposed Medicare on the basis of the financial burden it would produce.

If, because of the presumed urgency to get federal dollars flowing, combined with the efficiency of assignment, can convince congress that direct billing is contrary to the intent to provide for health care an administrative decision to eliminate the direct billing option will be supported legislatively.

If assignment only can be justified, then most certainly medicine can be controlled, and a vast step *has* been taken toward a federal system of medical care.

I am sure, Charlie, that your diagnosis of physician adaptation to Medicare is penetrating and correct. As you have suggested organized medicine has yet to demonstrate its full potential for leadership in the health field, but in the eyes of those who would control us there must be a void both in speed and degree in the job being done by the private sector.

Were I seeking to control medicine, seeking to bask in the power of such control; seeking to be the agent of the sole provider; I would welcome the confusion introduced into the reimbursement area as a subtle means of obtaining my goal.

"Yes" can be the only answer to your question "Medicare . . . does it represent that first step toward total governmental responsibility for medical care?"

I am most grateful for your reply. I am sorry that some of my members have seen fit to be critical of you or to make greater and less palatable the personal sacrifices you make to the honor of your office. I hope that despite Ohio's haste in criticism you may in the future look with pride at the support which Ohio has, and is in fact, given you in your devotion to protect the practice of medicine.

Finally, while I have been writing this letter, the mail arrived so I will answer February 6th letter: I have called a special meeting of Council for February 18th and 19th 1967, at which time Mr. Bell's letter and also Mr. Hess letter will be presented for discussion.

Sincerely,
LAWRENCE C. MEREDITH, M. D.
President, OSMA

AMA Judicial Council Opinion On Ethical Prescribing of Drugs and Devices

Following is the text of an opinion of the Judicial Council of the American Medical Association regarding ownership of or interest in drug firms and the ethical responsibilities of prescribing and dispensing drugs or devices. The opinion was adopted by the Judicial Council on March 12, 1967.

"It is unethical for a physician to be influenced in the prescribing of drugs or devices by his direct or indirect financial interest in a pharmaceutical firm or other supplier. It is immaterial whether the firm manufactures or repackages the products involved

"It is unethical for a physician to own stock or have a direct or indirect financial interest in a firm that uses its relationship with physician-stockholders as a means of inducing or influencing them to prescribe the firm's products. Practicing physicians should divest themselves of any financial interest in firms that use this form of sales promotion. Reputable firms rely upon quality and efficacy to sell their products under competitive circumstances, and not upon appeal to physicians with financial involvements which might influence them in their prescribing.

"Prescribing for patients involves more than the designation of drugs or devices which are most likely to prove efficacious in the treatment of a patient. The physician has an ethical responsibility to assure that high quality products will be dispensed to his patient. Obviously, the benefits of the physician's skill are diminished if the patient receives drugs or devices of inferior quality.

"Inasmuch as the physician should also be mindful of the cost to his patients of drugs or devices he prescribes, he may properly discuss with patients both quality and cost."

Today's Health Guide In Third Printing

Today's Health Guide, the American Medical Association's fast-selling manual of health information, has gone into its third printing, and is now available in book stores.

Still priced at \$5.95, the 640-page book is a compendium of information designed to help the family make the best and most economical use of health services. More than 250,000 copies have been sold.

The book helps the homemaker create an atmosphere, a "climate" in the home in which health will be favored, disease discouraged, and life prolonged and enriched.

Today's Health Guide is available through your bookseller or by mail order from the American Medical Association, 535 North Dearborn St., Chicago, Illinois 60610, for \$5.95. Check or money order should accompany each order.

Resolutions Which Will Be Considered At the 1967 Annual Meeting

HERE ARE THE TEXTS of resolutions which will be presented for consideration of the House of Delegates at the 1967 Annual Meeting of the Ohio State Medical Association, May 15-19, in Columbus. These resolutions were received at the Columbus Office on or before March 16, thereby meeting the 60-day deadline. No resolution which failed to meet the 60-day deadline may be introduced unless the sponsor secures at least a two-thirds consent vote of the delegates present at the meeting.

Copies of all resolutions presented to the Columbus Office have been sent to the individual Delegates and Alternate Delegates so that they may discuss them with their county medical societies, if they care to do so.

A resolution to be considered by the House of Delegates must be typed in triplicate; introduced by a delegate or his duly accredited alternate seated in his place; and introduced at the first session of the House of Delegates. This procedure must be followed even though the resolution may have been published in *The Journal* or sent in writing to all delegates prior to the meeting.

Business sessions of the House of Delegates will be as follows: First Session, Monday, (no meal to be served) May 15, starting with registration at 6:30 P. M. (Terrestrial Promenade, Second Floor—Sheraton-Columbus Hotel); followed by first Business Session at 8:00 P. M. (Saturn Room, Second Floor, Sheraton-Columbus Hotel). Final Session, Friday, May 19, at 9:00 A. M. (Saturn and Jupiter Rooms, Second Floor, Sheraton-Columbus Hotel). Meetings of the Resolutions Committees will be held all day Tuesday, May 16, and on Wednesday, May 17, if necessary. Inaugural Session—OSMA House of Delegates, Tuesday, May 16, at 2:30 P. M. (Mars and Venus Rooms, Second Floor, Sheraton-Columbus Hotel).

RESOLUTION NO. 1

Handling of Emergency Victims

(By the Wayne County Medical Society)

WHEREAS, a recent study of traffic fatalities indicated that people injured in rural counties were almost four times as likely to die of their injuries as those injured in urban counties, despite the occurrence of less severe accidents and more survivable injuries, and

WHEREAS, the higher case fatality ratio in rural areas seems to be related to the inability to provide adequate first aid procedure and to get the person to a hospital within a reasonable length of time, NOW THEREFORE BE IT

RESOLVED, that the Ohio State Medical Association adopt and help to implement, through the county medical societies, the five point program listed below to provide first aid training on a wider scope for rural Ohioans and swifter handling of emergency victims:

1. Rural communities coordinate their efforts with adjacent towns or urban centers in analyzing existing patterns of response to medical emergencies.
2. Rural and urban communities institute a medical service area program for emergency medical transportation facilities and health personnel.
3. Rural and urban communities, where possible, adopt standards for ambulance equipment, personnel and operation, liability insurance requirements, maintenance of records, and duties of regulatory agencies, and penalties, by ordinance, to be imposed if the standards are not met.
4. Rural and urban communities provide a program of advanced Red Cross first aid instruction for the non-medical people most frequently called in rural emergencies, especially police, sheriffs, and ambulance crews.
5. Rural and urban communities develop a continuing campaign directed toward first aid instruction for rural families and, particularly, young people through the schools, youth organizations, and other educational channels.

RESOLUTION NO. 2

AAPS Essay Contest

(By the Columbus Academy of Medicine)

BE IT RESOLVED, that the House of Delegates of the Ohio State Medical Association endorse the Essay Contest of the Association of American Physicians and Surgeons with the titles: (1) The Advantages of the American System of Private Medical Care and (2) The Advantages of the American Free Enterprise System.

RESOLUTION NO. 3

AMA Council on Medical Education

(By the Mahoning County Medical Society)

WHEREAS, resident training programs are conducted by the staff members of the individual hospitals concerned, and

WHEREAS, staff members of university hospitals are on full-time status in contrast to staff members of community hospitals who are also in private practice, but give of their time freely and with love for that which they are doing, and

WHEREAS, all are interested in maintaining residency training programs at the highest possible level, and

WHEREAS, it has been proven that a community hospital can provide a program as successfully as a university hospital, and

WHEREAS, the composition of the Council on Medical Education of the American Medical Association comprises a membership consisting heavily of medical school faculty or former faculty providing thus for a situation which can discriminate against community hospitals, THEREFORE BE IT

RESOLVED, that beginning on July 1, 1967, the majority membership of the Council on Medical Education shall consist of representatives of community-type hospitals.

RESOLUTION NO. 4

Podiatry

(By the Academy of Medicine of Cincinnati)

WHEREAS, the House of Delegates of the Ohio State Medical Association has adopted a previous resolution in reference to proposed amendments to the Medical Practice Act of the State of Ohio; and

WHEREAS, certain podiatrists are performing medical services beyond the scope of their training; and

WHEREAS, Section 4731.31 of the Revised Code of the State of Ohio, is antiquated through the use of the term "Chiropody" and the inclusion of hand surgery; NOW THEREFORE BE IT

RESOLVED, that the Medical Practice Act of the State of Ohio be amended to define legally what Podiatrists may be permitted to do in the State of Ohio by limiting their activities to the conservative treatment of the foot, excluding open surgery on hands, joints, tendons, muscles, ligaments, and blood vessels; AND BE IT FURTHER

RESOLVED, that the terms "hand surgery" and "chiropody" be deleted from the wording of the Medical Practice Act.

RESOLUTION NO. 5

To Endorse and Promote Legislation for the Establishment of an Air Pollution Control Board

(By the Academy of Medicine of Cincinnati)

WHEREAS, bills are now pending before the Senate and House of Representatives of the 107th General Assembly, Regular Session 1967-68, and further identified as Senate Bill 31 and H.B. 103, and

WHEREAS, effective legislation is needed to establish a Board with authority to set standards, adopt reasonable methods of enforcement, and enter into a pact with other states on a reciprocal basis for the purpose of decreasing the pollution of the air, and

WHEREAS, such legislation is necessary to effectively protect the general public; NOW THEREFORE BE IT

RESOLVED, that the Ohio State Medical Association adopt in principle the support of appropriate legislation and instruct the Legislative Committee to take any action deemed necessary to obtain the procurement of legislation that will establish an air pollution control board, AND BE IT FURTHER

RESOLVED, that the administration of the Air Pollution Control Board be under the control, jurisdiction, and guidance of the Department of Health, State of Ohio.

RESOLUTION NO. 6

Payment of Dues

(By the Academy of Medicine of Cincinnati)

WHEREAS, a number of County Medical Societies in the larger Metropolitan areas are experiencing budgetary problems which include expenses for the collection of dues of the Ohio State Medical Association and the American Medical Association; and

WHEREAS, the method of billing now requires the inclusion of the County, State, and National organizations in a single billing; and

WHEREAS, certain members of County Medical Societies have complained of the total amount that is billed at one time; NOW THEREFORE BE IT

RESOLVED, that The Council of the Ohio State Medical Association be authorized to study the dues problem in its entirety and make appropriate recommendations, AND BE IT FURTHER

RESOLVED, that The Council be instructed to notify all County Medical Societies of a hearing or hearings that are to be scheduled before a final policy is adopted in reference to the collection of dues.

RESOLUTION NO. 7

Group Malpractice Coverage

(By the Summit County Medical Society)

WHEREAS, this House recognizes the serious long-run threat to modern medical practice and the advance of medical science posed by the problems in underwriting malpractice insurance in today's court environment, hospital environment and technical environment for the physician, and

WHEREAS, these factors pose a threat to the standard of medical care by discouraging the entrance into or the practice of high-risk specialties, and,

WHEREAS, a broad education program is necessary for the public and the profession on the subject of malpractice and expert and specialized legal counsel in this field would be highly desirable, NOW THEREFORE BE IT

RESOLVED, that this House of Delegates requests The Council to develop specifications for and seek an underwriter for and establish group malpractice coverage plan for the members of the Ohio State Medical Association.

RESOLUTION NO. 8

Mental Health Centers

(By the Summit County Medical Society)

WHEREAS, the OSMA has previously indicated its desire and intent to assume a position of leadership in health programs at all levels, and

WHEREAS, we are now seeing the planning and establishment of community mental health centers as provided by PL 88-164, and

WHEREAS, there is evidence that many of these plans are being developed with little or no professional medical consultation or direction, and

WHEREAS, this method of development will create programs which transgress on the traditional methods of medical practice and hospital medical staff policies and in some instances, are in conflict with the principles of medical ethics and also the statutes of the State of Ohio, and

WHEREAS, a breach of established ethical principles and medical practice statutes will seriously jeopardize the quality of medical care rendered thus depriving many persons of appropriate treatment, NOW THEREFORE BE IT

RESOLVED, that the OSMA through its Council and the Committee on Mental Health investigate all such planning, by consultation with the Division of Mental Hygiene of the State of Ohio and the component county societies where such community mental health centers are planned so as to be cognizant of hazards inherent in the plans, AND BE IT FURTHER

RESOLVED, that in every instance where the plans will violate the principles of medical ethics that official notification be sent to the American Medical Association and the appropriate federal office to effect the necessary changes in the plan, AND BE IT FURTHER

RESOLVED, that in every instance where the plans seem to violate the statutes of the State of Ohio, that notification be sent to the Governor, Attorney General, and Director of the Department of Mental Hygiene and Correction of the State of Ohio asking that the error be corrected.

RESOLUTION NO. 9

Two More Ohio Medical Schools

(By the Summit County Medical Society)

WHEREAS, the ratio of physicians to population in the State of Ohio has remained essentially static for the past three years, and

WHEREAS, the increasing complexities of medical practice raise concern for our capacity, without an improvement in this ratio, to continue to provide high quality medical

care to the citizens of the State, to preserve the highest professional character of medical practice, and to maintain the traditional doctor-patient relationship, without excessive reliance on ancillary medical personnel, NOW THEREFORE BE IT

RESOLVED, that the Ohio State Medical Association continue to recognize its duty in advising and encouraging the government of the State of Ohio to provide adequately for the training of increased numbers of physicians, by instructing The Council of the Ohio State Medical Association to encourage the Ohio General Assembly and the Governor of the State of Ohio to assign top priority to the business of planning for and the beginning of construction of two more medical schools in Ohio by June 1, 1969.

RESOLUTION NO. 10

Areawide Health Care Planning

(By the Summit County Medical Society)

WHEREAS, the Congress saw fit to expand the program of Areawide Health *Facility* Planning into Areawide *Care* Planning with enabling legislation effective in Ohio, and

WHEREAS, the medical profession has been effectively excluded in several communities by hospital interests and others from meaningful participation in either program, and

WHEREAS, the structure of these areawide health care corporations places in their boards of trustees broad, centralized authority—over all health disciplines, the health departments, the hospitals, extended care facilities, ancillary personnel and suppliers, NOW THEREFORE BE IT

RESOLVED, that the Ohio State Medical Association House of Delegates instruct The Council to advise the appropriate state and federal offices of the danger to the public health inherent in this development.

RESOLUTION NO. 11

Changes in Regulations by the Ohio State Board of Health

(By the Academy of Medicine of Toledo and Lucas County)

WHEREAS, a serious shortage of hospital beds exists in Toledo and throughout Ohio resulting in long and costly waiting for admission for medical treatment and surgery, and

WHEREAS, construction of new hospital beds to accommodate these needs is costly and would be delayed for years, and

WHEREAS, the number of patients admitted to obstetric departments is everywhere decreasing leaving large numbers of maternity beds unoccupied, and,

WHEREAS, studies by the Chicago Board of Health and elsewhere have proven the safety of mixing obstetric and gynecologic cases for all patients involved, and

WHEREAS, the Illinois Hospital Licensing Board has changed its rules for licensing and now allowing such mixing under controlled conditions, and

WHEREAS, the Joint Commission on Accreditation of Hospitals already allows use of unused obstetric space for certain gynecologic and surgical cases, and

WHEREAS, use of such unused beds with proven safety would immediately increase effective hospital capacity throughout Ohio at no outlay of cash since all hospitals have unused maternity beds, THEREFORE BE IT

RESOLVED, that the Academy of Medicine of Toledo and Lucas County be recorded as in favor of all measures to effect the necessary change in regulations by the Ohio State Board of Health to permit the use of maternity beds by clean gynecologic and surgical cases, AND BE IT FURTHER

RESOLVED, that the Ohio State Medical Association support this Resolution and urge the Ohio State Board

of Health, the Ohio Hospital Association, and the Hospital Planning Associations throughout Ohio to support whatever legislation is necessary to provide more hospital beds in Ohio.

RESOLUTION NO. 12

Education of Nurses

(By the Academy of Medicine of Toledo and Lucas County)

WHEREAS, a serious shortage of nurses now exists in Ohio and the United States, and

WHEREAS, Licensed Practical Nurses with one year of training in bedside nursing, including women of varied backgrounds and ages who might be unavailable or ineligible for other professional nurse training programs, are now helping to correct the shortage of nurses by performing a substantial part of hospital nursing care, and

WHEREAS, it is desirable for selected professional nurses to take advanced academic training for a baccalaureate or higher degree, nevertheless the major part of hospital nursing care can be given by diploma-registered nurses or licensed practical nurses, and

WHEREAS, the National League for Nursing, and the American Nurses' Association, with support by the Ohio Board of Nursing Education and other similar State Boards, are proposing that all nursing education be moved out of hospital schools into the higher educational system, requiring two years of Junior or Community College for Associate Nurses who would eventually displace the Licensed Practical Nurses, and four years of college with baccalaureate degree for Registered Nurses, and

WHEREAS, this proposal would restrict and limit the number of nurses available for care of the sick, increasing the already critical shortage of nurses, and would add to hospital costs by forcing hospitals to employ higher salaried nurses in place of practical nurses, THEREFORE BE IT

RESOLVED, that the Ohio State Medical Association support the present system of hospital-based diploma schools of nursing and practical nursing, and that steps be taken to enlarge their enrollment in order to provide enough nurses with bedside training to meet the country's needs, to graduate nurses who are competent to assume the responsibilities of floor nurses in hospitals, and to do this at a reasonable cost, AND BE IT FURTHER

RESOLVED, that the Ohio State Medical Association and the American Medical Association use their influence to prevent a proposed educational program which would reduce the number and the practical competency of nurses.

RESOLUTION NO. 13

Physicians on Hospital Governing Boards

(By the Stark County Medical Society)

WHEREAS, physicians are generally sparsely represented on hospital governing boards (if indeed represented at all), and,

WHEREAS, such lack of representation has led to, and can lead to, unnecessary misunderstandings between medical staffs and hospital governing boards, and,

WHEREAS, most physicians are acutely aware of hospital problems, in many cases more so than nonphysician members of hospital governing boards, and

WHEREAS, many parochial institutions are modernizing to encourage representation of the laity on their governing boards, and,

WHEREAS, in some states, membership by physicians on hospital governing boards is required by law, and,

WHEREAS, the AMA has already approved the principle of having physician members on hospital governing boards, NOW THEREFORE BE IT

RESOLVED, that the Ohio State Medical Association record itself as being strongly in favor of the proposal

that not less than 25% of the voting members of hospital governing boards be physicians elected by the voting members of the medical staff of said hospital; the term of office of such physician members to be determined by the voting members of the medical staff, AND BE IT FURTHER

RESOLVED, that the Ohio State Medical Association take such actions as may be necessary to amend the laws of the State of Ohio to insure physician representation on hospital governing boards as described in this resolution, AND BE IT FURTHER

RESOLVED, that the delegates of the Ohio State Medical Association introduce this resolution in the next session of the House of Delegates of the American Medical Association in order to show further support of this proposal, and to request the AMA take all possible steps to make 25% physician representation on hospital governing boards a requirement for accreditation by the Joint Commission on Accreditation of Hospitals.

RESOLUTION NO. 14 Smoking and Health

(By John R. Huston, M. D., Delegate from Academy of Medicine of Columbus and Franklin County)

WHEREAS, cigarette smoking has been established as having a casual relationship with death and disability from lung cancer, coronary heart disease, emphysema, and chronic bronchitis, and

WHEREAS, death and disability from these diseases cause needless pain and anguish and millions of dollars in lost wages, medical expenses and hospitalization, and

WHEREAS, the conclusion of the Smoking and Health Advisory Committee to the Surgeon-General of the United States Public Health Service is that:

"Cigarette smoking is a health hazard of sufficient importance in the United States to warrant appropriate remedial action", and

WHEREAS, the following national organizations agree with the conclusion of the Smoking and Health Advisory Committee

American Association for Health, Physical Education,
and Recreation
American Association of School Administrators
American Cancer Society
American College Health Association
American Dental Association
American Heart Association
American Pharmaceutical Association
American Public Health Association
American School Health Association
Association of State and Territorial Health Officers
Department of Classroom Teachers of the National
Education Association
National Congress of Parents and Teachers
National League for Nursing
National Tuberculosis Association
U.S. Children's Bureau
U.S. Office of Education
U.S. Public Health Service
Affiliate Membership:
Boys' Clubs of America
National Board of Young Men's Christian
Association
National Board of Young Women's Christian
Association
National Student Nurses Association
Public Health Cancer Association of America

NOW THEREFORE BE IT

RESOLVED, that members of the Ohio State Medical Association, officially recognize their opportunities and responsibilities in this important field by

—modifying their personal habits as regards cigarette smoking
—participating actively in their practices and in community programs to influence and persuade both smokers and nonsmokers, not to smoke.

RESOLUTION NO. 15

Outside Affiliations of Members of Medical Staff
(By J. G. Tye, M.D., Delegate from Montgomery
County Medical Society)

WHEREAS, it has been no small part of the success of the progress in medicine and patient care in the United States of America that has come about thru the freedom of the right of each physician to determine without coercion or direction how and where he shall practice medicine; and

WHEREAS, it is to the best interest of medicine for all physicians, including the so called hospital based, to have the right and freedom to practice the art of medicine without restrictions by hospital administrations; and

WHEREAS, it is the function of the Medical Hospital Staffs to make appropriate recommendations to their Executive Staffs and the members thereof on all matters relating to the rendition of medical services to the patients of the hospital; NOW THEREFORE BE IT

RESOLVED, that the Ohio State Medical Association members be encouraged to have the Medical Staffs of Hospitals which they attend to go on record as recommending that its members may have affiliations in corporations, partnerships, associations, or other organizations in addition to the affiliation with the Medical Staff; providing that outside affiliations are legally acceptable and in conformance with the principles of good medical ethics; AND BE IT FURTHER

RESOLVED, that the Hospital Medical Staffs to whom our members belong recommend that the existence of such outside affiliations on the part of any physician shall not be a disqualification in any manner whatsoever to his being accepted as a member of the Medical Staff or to providing services to patients in that particular hospital; AND BE IT FURTHER

RESOLVED, that the Medical Staffs of these hospitals instruct the Executive Committee or any Committee representing the Medical Staff in its relations with the administration of the Hospital that the foregoing principles shall be applicable in all matters pertaining to the rendition of services to patients at the Hospital by the Medical Staff.

RESOLUTION NO. 16

Quality Medical Care

(By the Second Councilor District Delegates)

WHEREAS, all the people of the State of Ohio do deserve and do get the maximum quality of medical care to the best of the ability of the doctors of Ohio to provide same; and

WHEREAS, organized medicine is continuously devoted to the provision of maximum quality medical care; and

WHEREAS, publicity received by organized medicine of the State of Ohio does not always demonstrate to the people of Ohio the great dedication of doctors to the principles of maximum quality care for everyone; THEREFORE BE IT

RESOLVED, that the House of Delegates of the Ohio State Medical Association in speaking for organized medicine in the State of Ohio does hereby reaffirm the dedication to the highest principles and practices of medical care for all of the people of the State of Ohio regardless of race, color, religion, or economic status.

RESOLUTION NO. 17

Reapportionment for Equitable Representation

(By Academy of Medicine of Cleveland)

WHEREAS, American medicine has taken pride in the fact that its local and state organizations are truly representative of the physician-members they serve, and

WHEREAS, recent judicial rulings have stressed that the representation of voters in legislative councils should by right be equal, and

(Continued on Page 674)



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Indications: Tuinal, comprised of equal parts of Seconal® Sodium (sodium secobarbital, Lilly) and Amytal® Sodium (sodium amobarbital, Lilly), is indicated for prompt and moderately long-acting hypnosis. Not suitable for continuous daytime sedation.

Contraindications: Barbiturates should not be administered to anyone with a history of porphyria, nor should they be given in the presence of uncontrolled pain, because excitement may result.

Warning: May be habit-forming.

Precautions: Tuinal should be used cautiously in pa-

tients with decreased liver function, since prolongation of effect may occur.

Adverse Reactions: Idiosyncrasy, such as excitement, hangover, or pain, may appear. Hypersensitivity reactions occur in some patients, especially in those with asthma, urticaria, or angioneurotic edema.



Dosage: 1½ to 3 grains at bedtime.

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WHEREAS, shifts in the general population in Ohio have forced many physicians to concentrate their practices in larger urban centers, and

WHEREAS, delegate to member ratios in the Ohio State Medical Association, formerly quite similar throughout the state, now range from a high one delegate to 97 members in two counties to a low of one delegate to 0 members in one county, making it possible for the voting power of approximately 25 per cent of the membership of the Association to equal the voting power of the remaining 75 per cent, and

WHEREAS, comparison of delegate-membership ratios in 1966 with those from 1965 indicates that this inequality of representation is increasing, NOW THEREFORE BE IT

RESOLVED, that a reapportionment of delegates to the Ohio State Medical Association should be effectuated so that each member is equally represented in the House of Delegates, AND BE IT FURTHER

RESOLVED, that the methods be adopted to adjust this apportionment every 5 years so that representation of members remains equal at all times, AND BE IT FURTHER

RESOLVED, that appropriate amendments to the Constitution and Bylaws of the Ohio State Medical Association to effect such equal representation and periodic review be prepared by the Legal Counsel, under the supervision of The Council of the Association and be presented for action by this House of Delegates at the Annual Meeting in 1968.

RESOLUTION NO. 18

Certification

(By the Columbus Academy of Medicine)

WHEREAS, there have been instances in Ohio of members of the Ohio State Medical Association being deprived of hospital privileges as a result of strict adherence to the policies laid down by the Ohio State Medical Association and the American Medical Association relative to certification and recertification of medical necessity, NOW THEREFORE BE IT

RESOLVED, that the Ohio State Medical Association establish a permanent committee to investigate such instances and devise effective methods of supporting the stand of physicians so affected.

RESOLUTION NO. 19

Legality of Blue Cross Coverage of Professional Fee for Medical Services Performed in a Hospital

(By the Montgomery County Medical Society)

WHEREAS, in 1966 the efforts of hospital-based specialists to bill patients direct for their professional fees were consistently opposed by Blue Cross plans; and

WHEREAS, most direct billing plans that have been achieved still have varying degrees of hospital and Blue Cross intervention; and

WHEREAS, ethical, direct billing depends on freedom from Blue Cross control; and

WHEREAS, payment to physicians of professional fees by Blue Cross is termed illegal by officials of some Blue Cross plans including the officials of Hospital Care Corporation, the Southwestern Ohio Blue Cross plan; THEREFORE BE IT

RESOLVED, that the Ohio State Medical Association determine the legality of the writing and sale of policies by Blue Cross which include provision for payment of professional fees; AND BE FURTHER

RESOLVED, that if the writing and sale of such policies is found to be illegal, the OSMA shall seek an immediate injunction against those Blue Cross plans which are in violation to prevent the writing and sale of any such policies in the future.

RESOLUTION NO. 20

Measles Immunization

(By the Mahoning County Medical Society)

WHEREAS, an effective vaccine for the control of Measles (Rubeola) has been available to physicians and their patients for more than three years, and

WHEREAS, the medical profession, the Surgeon General of the United States, and various official Health Departments and agencies have agreed on the importance and necessity of eradicating this disease, and

WHEREAS, the state of Ohio has made it mandatory that children receive certain immunizations for the prevention of diphtheria, whooping cough, tetanus, smallpox, and poliomyelitis, before entering school, THEREFORE BE IT

RESOLVED, that the Ohio State Medical Association take steps to make it mandatory that children, before entering school, either have a measles immunization or show positive evidence of having had this disease.

RESOLUTION NO. 21

Delinquent State Accounts

(By the Huron County Medical Society)

WHEREAS, it is usual and customary for Governmental Revenue Agencies to collect due bills on the specified dates or else add accrued interest, and

WHEREAS, it is good and accepted practice for bills to be paid on due dates and

WHEREAS, the Department of Welfare of the State of Ohio has been notoriously negligent in discharging its obligation of readily paying doctor bills for services rendered to Welfare recipients, THEREFORE BE IT

RESOLVED, that the doctors of Ohio consider all bills and accounts unpaid over three months as delinquent AND BE IT FURTHER

RESOLVED, that hereafter the submitted bills shall be paid monthly—the latter being a reasonable suggestion in these days of modern computerized means, AND BE IT FURTHER

RESOLVED, that a current rate of interest be added to all delinquent accounts owed by the State—a practice followed by Governmental Agencies when collecting from taxpayers.

RESOLUTION NO. 22

Possible Violation of Antitrust Laws by the Federal Government in Concert with Blue Cross-Blue Shield Organizations Throughout the Country

(By the Huron County Medical Society)

WHEREAS, there has been a concerted, nationwide aggressive effort both by the many Blue Cross-Blue Shield Plans and the Federal Government to coerce senior citizens to sign up for Part B of Medicare; informing them that Part A was automatic and did not need their consent; and

WHEREAS, many of these Blue Cross and Blue Shield Plans have indeed literally forced these same senior citizens to sign up by virtue of their having informed said citizens that their previously held contracts with said companies would be automatically cancelled starting June 30, 1966; and

WHEREAS, Section 1801, 1802, and 1803 of the Medicare Laws read as follows—respectively, to wit:

"Section 1801.—Nothing in this title shall be construed to authorize any Federal office or employee to exercise any supervision or control over the Practice of Medicine or the manner in which medical services are provided or over the selection, tenure, or compensation of any officer or employee of any institution, agency, or person providing health services; or to exercise any supervision or control over the administration or operation of any such institution, agency, or person.

"Section 1802.—(Free choice by patient guaranteed).—Any individual entitled to insurance benefits under this title may obtain health services from any institution, agency, or person qualified to participate under this title if such institution, agency, or person undertakes to provide him such services.

"Section 1803. (Option to individuals to obtain other health insurance protection).—Nothing contained in this title shall be construed to preclude any State from providing, or any individual from purchasing or otherwise securing, protection against the cost of any health services; and

WHEREAS, it would seem reasonable to conclude that both the Federal Government and the aforementioned Blue Cross-Blue Shield Organizations have been in violation of the spirit and the intent of the Medicare Law if not indeed in the actual transgression of same—with respect to Sections 1801, 1802, and 1803—and perhaps have even violated Antitrust Laws; and

WHEREAS, it seems to be United States Government's intent to involve itself progressively more in the practice of Medicine—To Wit—

Mr. Forand—"If we can only get our foot in the door we can go on from there."

Senator Russell Long—"It is inevitable that Medicare be extended to cover everybody, young and old. The next group will be the disabled."

this in spite of the fact that, in essence, the voting public in the November 1966 election, 'rejected' the Medicare Law foisted upon them; THEREFORE BE IT

RESOLVED, that the House of Delegates of the Ohio State Medical Association submit to the House of Delegates of the American Medical Association a resolution requesting that the AMA through its appropriate liaison committee request the Federal Government to reintroduce Freedom of Choice to the senior citizens of their hospitalization and/or insurance contracts by refunding to said citizens equivalent dollars of cost of both Part A and Part B of Medicare; AND BE IT FURTHER

RESOLVED, that the AMA advise all such hospitalization organizations to reinstate the previously held contracts to these senior citizens; the later for the following reasons:

1. To introduce a spirit of competition with a federal, bureaucratic, monopolistic, unfair competitor.
2. To offer Free Choice to the patients, as prescribed by law.
3. To invigorate and perpetuate the Free Enterprise System.
4. In keeping with precepts of a Free Economy which precepts made this Nation and American Medicine the envy of the world.
5. To help evict the government from the practice of Medicine.
6. To prevent the government from absorbing functions of the insurance industry of the Country.
7. To properly point out to government authorities that the primary function of our constitutional, democratic form of representative government is National Defense and the preservation of order and peace.

RESOLUTION NO. 23

OSMA Executive Vice-President Resolution

(By the Huron County Medical Society)

WHEREAS, the practice of medicine has suddenly been catapulted into the political arena; and

WHEREAS, the Medico-Political-Socio-Economic developments emanate at a very fast pace and create many problems which need solutions; and

WHEREAS, a Doctor of Medicine is admittedly not best qualified to deal effectively with many of the problems by virtue of:

1. Lack of adequate training in some of said fields; and
2. His primary life's mission—namely, to render the best

medical care he can to all possible, within his capabilities; THEREFORE BE IT

RESOLVED, that the Ohio State Medical Association employ an Executive Vice-President with the highest possible qualifications to represent the Ohio State Medical Association in all matters of arbitration, negotiations, and legislation pertaining to Medical-Legal and Socio-Economic matters.

RESOLUTION NO. 24

Freedom

(By the Huron County Medical Society)

WHEREAS, Section 1801 of Public Law 89-97 (Medicare) reads as follows: "Nothing in this title shall be construed to authorize any federal office or employee to exercise any supervision or control over the Practice of Medicine or the manner in which medical services are provided, or over the selection, tenure, or compensation of any officer or employee of any institution, agency, or person providing health services; or to exercise any supervision or control over the administration or operation of any such institution, agency, or person"; and

WHEREAS, the House of Delegates at the AMA convention in June, 1965, adopted that "When Government assumes financial responsibility for an individual's health care, reimbursement for professional services should be on the same basis as in the case of other indispensable elements of health. Therefore, reimbursement of the services of Physicians participating in Government-supported programs should be on the basis of usual and customary fees"; and

WHEREAS, the "usual and customary fee" basis "is a proven method of providing service benefits at acceptable cost"—(Carl A. Tiffany, Chicago; Consulting Actuary for a number of State Medical Associations); and

WHEREAS, there is no longer a question of Doctors helping financially distressed people who need help—rather, a matter of expecting the Government to pay "usual and customary fees" for the health care services promised to its beneficiaries—the people; and

WHEREAS, the Ohio State Department of Public Welfare agreed to abide by the above principles and in good faith let it be known to the Physicians of Ohio in a communication on August 5, 1966 through Chief F. J. Zuber; and

WHEREAS, the Ohio Department of Public Welfare, by direction from HEW, through Chief J. W. Main, in a communication to Ohio Physicians dated October 21, 1966 and titled "BILLING PROCEDURES—CHARGE FOR SERVICES PROVIDED ON AND AFTER JULY 1, 1966 TO RECIPIENTS 65 YEARS OF AGE AND OVER"—stated that—"The assignment method appears to be the only practical way for handling bills for services rendered to welfare recipients—etc.—" and

WHEREAS, in this latest communication the Ohio Department of Public Welfare and HEW purport to:

- A. act contrary to Public Law 89-97;
- B. act unilaterally in retracting, without notification and/or consultation, a previously binding and ethical agreement made in good faith;
- C. override the Department of HEW which has stated that *any* billing statement with adequate information is acceptable; and

WHEREAS, the Physicians of Ohio are not federal employees nor State employees and are vitally interested in the preservation of Freedom for all, especially for progeny—THEREFORE, BE IT

RESOLVED, that the Ohio Department of Public Welfare and HEW retract its actual and purported unethical and unlawful transgressions with an immediate public statement; AND BE IT FURTHER

RESOLVED, that unless such is done, OSMA Council advise each Ohio Physician of this resolution and urge them strongly to send a letter to each one of their welfare

patients explaining to them that we Doctors are no longer freely allowed to care for them.

RESOLUTION NO. 25

Centurion Committee

(By the Huron County Medical Society)

WHEREAS, the AMA Board of Trustees refused to implement the House of Delegates approved Oregon Resolution 104 which states—"Resolved that since separate billing by the Physician for his professional services is a preferred ethical practice, it shall be deemed unethical for a Physician to displace a hospital-based Physician who is attempting to practice separate billing when said displacement is primarily designed to circumvent separate billing"; and

WHEREAS, the Board of Trustees explained that their action was taken because of the FEAR of *possible* violation of antitrust laws; and

WHEREAS, possible undue fear of government prosecution via antitrust laws has been perhaps unhealthily and repeatedly overemphasized; and

WHEREAS, said undue fear may prevent active action necessary to the preservation of the very existence of a representative, constitutional democracy; and

WHEREAS, basic, proven, moral, ethical, medical, and socio-economic principles for the Practice of Medicine in a Free Atmosphere are being destroyed by hastily drawn legislative action which:

- a. in many instances is contrary even to constitutional principles.
- b. would eventually and unquestionably lead to total Socialized Medicine; and

WHEREAS, Socialized Medicine will result in inferior overall medical care for all; and

WHEREAS, there are times in the evolution of Time and History of Man when it becomes irrevocably and unalterably incumbent for Man to act, without choice, reaffirm his convictions in Godly, eternal truths, in an attempt to check loose, and even reckless, superficially facile and expedient ways of despotism; THEREFORE BE IT

RESOLVED, that the Physicians of Ohio, through the OSMA, form a CENTURION COMMITTEE, to perpetuate a milieu or atmosphere of FREEDOM wherein to practice Private Medicine. The details, functions, and operations of said Committee are to be as follows:

1. Each member of OSMA will be given the opportunity to pledge \$100 to the treasury of said Committee; the potential funds to be used solely for the purpose of legal counsel and defense in a possible antitrust suit against OSMA or a suit started by OSMA against the Federal Government. (The latter possibility since it is incumbent upon all of us to preserve freedom for all).
2. The pledge shall be made binding, except—it be automatically dissolved at the death of the member.
3. The necessary officials and legal counsel of said Committee shall be appointed by the OSMA Council. (Suggestions may be sent in by OSMA members).

4. The Committee shall adopt a motto as follows, which it may inscribe on its stationery—"THERE IS NO HELP FOR THE WORLD IF WE ALLOW OUR APPETITE FOR COMFORT TO GET IN THE WAY OF OUR COMMITMENTS OF HONOR." (Secretary-of-State Dean Rusk)

5. The Committee shall have an insignia as follows—a lapel pin consisting of the Medical Insignia with the word FREEDOM at the top of the staff and the word CENTURION at the bottom of the staff, which it may inscribe on its stationery. Said pin to be issued to each member upon his pledging the \$100. The latter details to be worked out between the appropriate Committee Representative and the Executive Secretary of each County Medical Society in the State of Ohio.

RESOLUTION NO. 26

Out-Patient Diagnostic Procedures Resolution

(By the Huron County Medical Society)

WHEREAS, the Federal Government is already excessively involved in the practice of medicine; and

WHEREAS, enactment of a presumably proposed 'Preventicare Bill' by Senator Harrison would add even more to the Government Practice of Medicine; THEREFORE BE IT

RESOLVED, that the Blue Cross and Blue Shield Plans and all voluntary Health Insurance Agencies, with the help of the Medical Societies, develop Health Insurance Policies to cover expenses for Out-Patient Diagnostic Procedures which might be carried out either in hospitals and/or Doctor's offices.

RESOLUTION NO. 27

Chiropractic

(By the Huron County Medical Society)

WHEREAS, Charles L. Hudson, President of the AMA, has recently proposed that "A program of critical self-examination as a demonstration of professional competence for the nation's Physician population" be instituted, while addressing the First National Congress on the Socio-Economics of Health Care, in Chicago; and

WHEREAS, the intent and spirit of Public Law 89-97 (Medicare) is to offer medical services to a certain segment of the nation's population; and

WHEREAS, certain states have included Chiropractors essentially as 'doctors' and as 'providers of services' thereby being included in Title 19—comparable to Medical Doctors; and

WHEREAS, Chiropractic is a cult and not a Medical Profession; THEREFORE BE IT

RESOLVED, that Counsel of OSMA instruct the American Medical Association to make both the Department of Health, Education, and Welfare and the United States Congress aware of these facts and thereby prevent Chiropractors (Cultists) from rendering medical services under the Medicare Law. The mandate based on the fact that said Cult is totally unqualified to render medical services.

Candidate for the Office of President-Elect of OSMA

UNDER revised Section 1 (a) of the OSMA Bylaws, the following name of a candidate for the office of President-Elect has been filed with the Executive Secretary 60 days prior to the meeting of the House of Delegates at which the election is scheduled to take place, that is on May 19 during the 1967 Annual Meeting of the OSMA in Columbus:

THEODORE L. LIGHT, M. D.

Dayton, Ohio



CURRICULUM VITAE

Office: 2670 Salem Avenue, Dayton, Ohio 45406

Residence: 2670 Salem Avenue, Dayton, Ohio 45406

Type of Practice: Internal Medicine

Born: January 3, 1905, Dayton, Ohio

Education: Pre-Med, University of Cincinnati; M. D., University of Cincinnati College of Medicine, 1937; Intern, Miami Valley Hospital; Resident, Miami Valley Hospital

Military Service: Captain, M. C.; Flight Surgeon, 319th Bomber Group, Mediterranean Theater, 1942-1945

Hospital Staff: Consultant Staff, Good Samaritan Hospital

Affiliations: Courtesy Staff, Kettering Memorial Hospital, Miami Valley Hospital, St. Elizabeth Hospital

Montgomery County Medical Society Offices and Activities: Council Member, 1947-57; Secretary, 1947; Vice-President, 1948 and 1951; President, 1955; Delegate to OSMA, 1950-63; Received "Outstanding Service Award," 1956

Ohio State Medical Association Activities: Member since 1938; Second District Councilor since 1963; Alternate Delegate to AMA, 1959-63; Delegate to AMA since 1964

Montgomery County Medical Society

March 6, 1967

Mr. Hart F. Page
Executive Secretary
Ohio State Medical Association
17 South High Street
Columbus, Ohio 43215

Dear Mr. Page:

In accordance with revised Section 1 (a) of the Ohio State Medical Association Bylaws, the undersigned are privileged to nominate Theodore L. Light, M. D., 2670 Salem Avenue, Dayton, Ohio, as a candidate for the office of President-Elect of the Ohio State Medical Association.

Dr. Light is a member in good standing of the Montgomery County Medical Society, the Ohio State Medical Association and the American Medical Association. He is currently serving as Councilor for the Second District OSMA. His curriculum vitae is attached.

Respectfully submitted,
J. Richard Strawsburg, M. D.
Delegate

W. J. Lewis, M. D.
President

Professional Societies: Montgomery County Medical Society; Ohio State Medical Association; American Medical Association

Other: Aero Space Medical Association

Civil Aviation Medical Association

Dayton Area Heart Association Executive Board

Hospital Planning Council of the Greater Miami Valley Medical Advisory Committee

Industrial Medical Association

Kettering Memorial Hospital Foundation

Medical Advisory Committee—Cochairman

Building Plans Committee—Chairman

(Continued on Next Page)

(Candidate—Cont'd)

Montgomery County Society for Cancer Control Executive Board

Ohio Department of Welfare—Governor's Advisory Committee for Title XIX since February, 1966

Community Activities: Boy Scouts of America: Miami Valley Council since 1940, District Health and Safety, District Leadership Training, Council Health and Safety, Council Commissioner, Awarded "Silver Beaver," 1953

Camp Fire Girls: Executive Board of the Dayton and Miami Valley Council; Member, 1949-54; President, 1953-54; Received "Gulick Award," 1960

Chamber of Commerce
Solicitations and Review Committee

Dayton Board of Education, 1954-65—Vice President

Dayton Kiwanis Club: Member since 1941, President, 1951

Member: St. Andrew's Episcopal Church
Vestryman and Senior Warden

Married: Dr. Light lives with his wife, Nina, a registered nurse. They have four children: a son, Richard, who is a Medical Doctor; three daughters, Linda, Eleanor and Mary Ellen. Linda and Eleanor are registered nurses. Mary Ellen is a student at home.

Workmen's Compensation Payments To Be Made 13 Times a Year

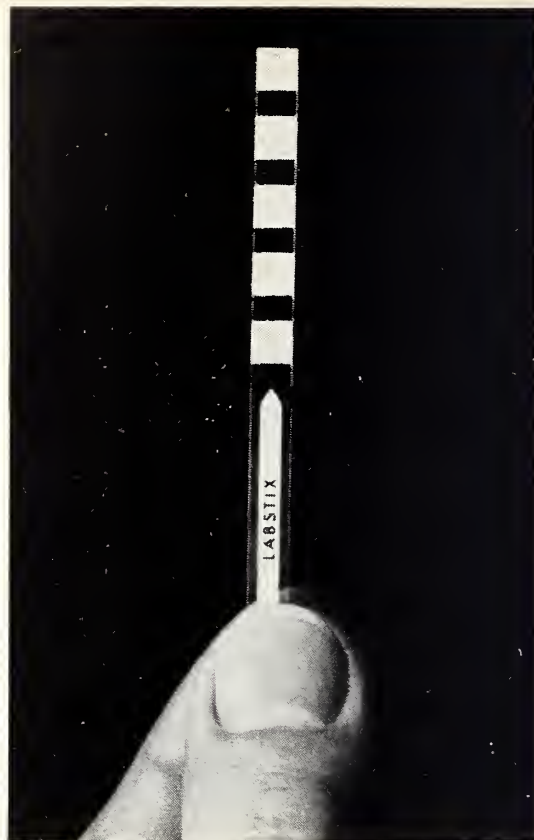
The Bureau of Workmen's Compensation of Ohio recently announced a new schedule of payments under its medical plan which will give faster and better service for physicians who provide services under the Bureau's program, according to an announcement by Elmer A. Keller, administrator.

Effective March 31, 1967, warrants are being mailed every four weeks instead of monthly. This change results in medical expenses being paid 13 times each year instead of 12 times as was the former practice.

Announcements of this change were scheduled to be mailed to physicians with the March 31 and April 28 medical payments.

Schedule of approximate mailing dates for the last ten payment periods of 1967 are the following: March 31, April 28, May 26, June 23, July 21, August 18, September 15, October 13, November 10, and December 8. A similar schedule will be forthcoming for 1968 payments.

Dr. V. William Wagner spoke on the subject of birth defects at a meeting of the Port Clinton Junior Civic Club.



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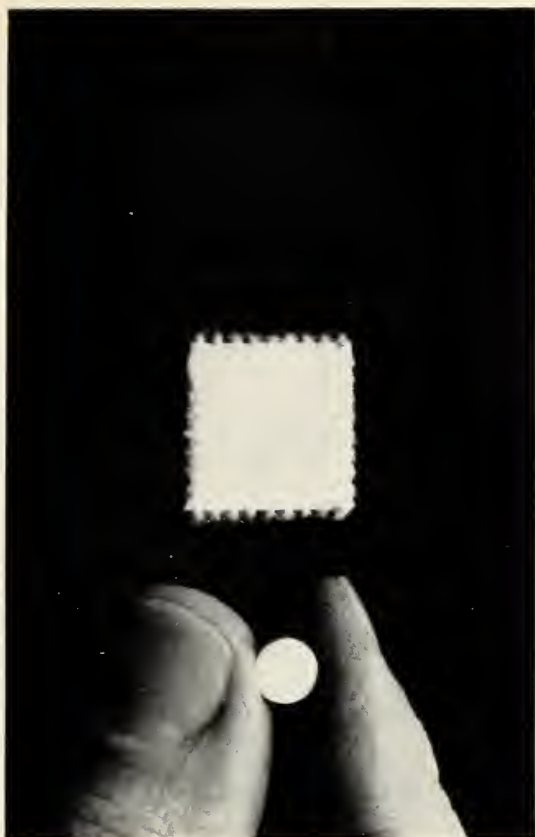
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Elkhart, Indiana 46514



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Note: AMERICAN HOSPITAL FORMULARY SERVICE
CATEGORY NUMBER 36:88 40167

Do You Know? . . .

Dr. Frederick T. Merchant, Marion, is author of an article, entitled "Curriculum, Content and Candidate Evaluation in Professionalism," which appeared in the February issue of the Federation Bulletin, publication of the Federation of State Medical Boards of the United States. Dr. Merchant is a member of the State Medical Board of Ohio, and is Councilor of the OSMA Third District.

Dr. Robert E. Sooy, of Mt. Vernon, was among a group of physicians who volunteered for a 60-day tour of service in Vietnam under the Volunteer Physicians for Vietnam program sponsored by the American Medical Association.

Dr. Charles Marks, associate director of surgery at Marquette University, Milwaukee, Wisconsin, has been named director of the Division of Surgery at Cleveland's Mount Sinai Hospital, effective July 1.

At the invitation of the Venezuelan Society of Tuberculosis and Lung Disease, Dr. Benjamin Felson presented a course on chest x-ray in Caracas. He is professor and director of the Department of Radiology at the University of Cincinnati Medical Center. Dr. Felson is currently chairman of the Commission on Education of the American College of Radiology.

Dr. Charles L. Hudson, Cleveland, President of the American Medical Association, gave the keynote address at the annual meeting of the Ohio College Health Association, on the Wittenberg University campus in Springfield. His topic was "What Is the AMA?"

A check for \$8,000 to support research in anemia in the University of Cincinnati Department of Internal Medicine was presented recently by the Hotel and Restaurant Employees and Bartenders International Union which has its headquarters in Cincinnati.

While on a recent trip to the Far East, Dr. Claude S. Perry, Columbus, presented a seminar on "Diabetic Retinopathy" before the medical staff of the Hospital of American Samoa at Pago Pago. He also addressed medical groups in Auckland, New Zealand; Singapore and Manila.

Dr. Willem J. Kolff, specialist in kidney dialysis and artificial organs, has resigned as head of the Department of Artificial Organs at the Cleveland Clinic. He will take a post this summer at the University of Utah College of Medicine.

OSMA Puts Its Position on Record, Re: Proposed SS Amendments of 1967

THE Ohio State Medical Association has taken a firm stand in regard to H. R. 5710, otherwise known as the proposed "Social Security Amendments of 1967," and stated its opposition in correspondence with Ohio legislators in Washington. Following is the text of a letter from OSMA President Lawrence C. Meredith to Ohio Congressman Betts, with the text of certain other documents. Copies of the correspondence went to all Ohio Congressmen and to Ohio's Senior Senator, Frank J. Lausche.

March 31, 1967

U. S. Representative Jackson E. Betts
Member, Committee on Ways and Means
House Office Building
Washington, D. C. 20515

Dear Congressman Betts:

On behalf of the Ohio State Medical Association and its 10,000 physician members, I earnestly solicit your attention to and support of the position of this Association regarding:

1. H. R. 5710, "Social Security Amendments of 1967," currently being heard by the Committee on Ways and Means, and
2. Certain changes necessary to Public Law 89-97, The Medicare Act, and rules, regulations, and interpretations pursuant thereto.

H. R. 5710 is a hasty, ill-conceived and baseless bill. Prepared by the U. S. Department of Health, Education, and Welfare, it has been offered to the Congress before the true picture of the vast costs and other ramifications of Titles XVIII and XIX can be accurately assessed.

For example, there were 50,000 unpaid bills for medical services to Ohio's Aid for the Aged recipients, most claims involving Medicare Part B as well, when the Social Security Administration was publicly announcing in January the alleged cost of the Medicare program for its first six months. In addition, Ohio's hospitals had thousands of Medicare Part A claims that had not been processed or paid.

The Ohio situation is the rule rather than the exception, for physicians and hospitals throughout the nation had unpaid claims in the hundreds of thousands when H. R. 5710 was being written. Most of the claims remain unpaid at this writing.

Another fact we wish to call to your attention is

found on page 19 of the "Section-by-Section Analysis and Explanation of Provisions of H. R. 5710," prepared for the Committee on Ways and Means by the U. S. Department of Health, Education, and Welfare.

Mandatory "Contributions"

On that page is found a chart in which the Social Security taxes are referred to, not once but seven times, as contributions." Describing a mandatory tax as a "contribution" is being less than honest.

This Association's position on H. R. 5710 can best be presented by reference to the following sections of the bill:

Section 125, "Health Insurance for the Disabled." This proposal would add heavily to the already overburdened fiscal resources of the Social Security program before a truly accurate knowledge of the fiscal effects of P. L. 89-97 has been established. Further, Title XIX and other programs provide financial resources for helping those disabled who need help.

Section 126, "Health Insurance Payments to Federal Facilities." This proposal would place additional fiscal responsibility on the Social Security trust fund for programs that already have been financed by the Congress through other government agencies. In effect, it would shift to the Social Security trust fund fiscal responsibility for which these agencies were created.

Section 127, "Inclusion of Nonroutine Podiatrists' Services Under the Supplementary Medical Insurance Program." This section is highly questionable since it would limit coverage to services that only a physician is qualified to perform, or performed by a podiatrist in a hospital directly under the supervision of a physician.

Section 128, "Increase in Membership of the National Medical Review Committee." This section, as does the original act, fails to provide for meaningful representation on the committee by privately practicing physicians. In other words, that segment of the profession that provides a vast majority of the medical service is not specifically represented on this important body.

Section 129 (b), (c) . . . "And to Provide Programs of Health-Care Facility Planning." It has been our unfortunate experience that the federally financed health facility planning programs tend to neglect the medical profession in initiating, program-

ming and activating health facility planning, thereby totally ignoring the one profession that can provide medical care — the medical profession.

Hospital-Based Physicians

Section 130, "Part C — Outpatient Hospital and Diagnostic Specialty Benefits for the Aged and Disabled." As has been attempted in rules and regulations regarding reimbursement of the so-called hospital-based physicians, this is a blatant effort to treat certain physicians as hospital employees. In enacting P.L. 89-97, Congress provided two parts for Medicare — Part A for hospital benefits and Part B for supplemental medical insurance benefits.

Congress specifically provided that physician services were to be covered under Part B. The attempted establishment of Part C, by providing for payment of certain in-hospital medical services out of the Federal Hospital Insurance Trust Fund, is totally contradictory.

Further, H.R. 5710 would provide for 100 per cent payment for these so-called "specialty services," while retaining the 20 per cent deductible feature of other medical services. This is highly inconsistent inasmuch as a medical service is a medical service, whether it be provided by a pathologist, radiologist, surgeon, internist, or family physician, and payment should be made accordingly.

The proposed Part C is an outright and patent attempt to correct an administrative fiasco that exists in the Medicare program. It is even more ridiculous when one considers that the direct solution of these so-called specialty services problems could best be provided through payment for these services in the same manner as other medical services — out of Part B funds and directly to physicians.

Further, the fact remains that physicians, not hospitals, provide medical services. In many states, including Ohio, hospitals are specifically prohibited from practicing medicine. Now we are faced with an attempted federal statute that would declare that a medical service is a hospital service. This is totally unacceptable to the medical profession, and conflicts with certain state laws.

A similar attempt was made in the original Medicare bill, and this was rejected by the Congress.

Section 131, "Elimination of Requirement of Physician Certification in the Case of In-Patient Hospital Services at Time Individual Becomes an In-Patient." This Association supports the elimination of certification upon admission. However, Section 131 does not go far enough. It fails to eliminate recertification.

Certification and recertification are reprehensible to the medical profession. They reflect improperly on the integrity of the physician. They fail to recognize that the physician's admission and progress notes are ample evidence of the need for admission to and continued stay in the hospital, well recognized by

EXHIBIT A

Cut MD Paper Work, Doctor Urges

Dr. Milton Silverman, of the Department of Health, Education, and Welfare, says one way to increase the number of physicians in the U. S. would be to increase their efficiency by reducing their paper work and other nonmedical duties.

"A 4 per cent increase in the efficiency of all our doctors would be the equivalent of 11,700 more physicians," Dr. Silverman told a Cincinnati Academy of Medicine meeting here last night.

Dr. Silverman said the U.S. needs more health workers of all kinds, including physicians. He said the country is getting "some help," however, from the immigration of 1200 new foreign physicians a year to the U.S. Many of these are from England.

Dr. Edgar Parry, Liverpool surgeon who shared the Academy speakers' program, said 400 doctors a year leave England — because of socialized medicine, poor research facilities and the fact they can make more money elsewhere.

"There are 2500 patients per doctor in England," Dr. Parry said, "while there are 442 patients per doctor in Hamilton County." — *Cincinnati Post & Times Star*, Nov. 16, 1966.

the Joint Commission on Accreditation of Hospitals, courts and the insurance industry.

In its analysis, HEW states, page 29, "Effects of the Proposal," that "The procedure that would be followed to avoid payment for unneeded care would include screening by the administering agencies to isolate those cases in which the diagnosis and treatment raised questions about the medical necessity, and action would be taken to resolve these questions."

This is ambiguous. HEW says that certification is not needed, then says screening by administrative agencies is needed, fails completely to say how the questions would be resolved, and does not present one shred of evidence supporting the necessity for such screening.

The public press is redundant with Social Security Administration claims that the Medicare program is functioning smoothly. If this is true, then why this unsubstantiated allusion to treatment without medical necessity?

What "action would be taken to resolve these questions?" Failure of the HEW analysis to clarify this statement is viewed with suspicion and concern.

On the same page, under the heading "Background," is the statement that the American Medical Association House of Delegates "has adopted a resolution urging the AMA to work for the repeal of the certification requirements." This is a half-truth. The resolution of the House of Delegates directed the AMA to work for repeal of both certification and recertification. HEW should present the Committee with all the facts.

Certification and recertification also fail to recognize that this same area is covered by utilization review committees, and add unnecessarily to the overwhelming paper work that confronts physicians today.

It is ridiculous for HEW to support this procedure when, at the same time, a spokesman for the Department states that reducing paper work and other non-medical duties of physicians would be the equivalent of 11,700 additional physicians in our nation (See Exhibit A).

Section 167. "Redesignation of Old-Age Insurance Benefits." This proposed change from "old-age" to "retirement" in the Social Security Act aptly illustrates one of the cruelest hoaxes in the Social Security program. The hoax is that the worker who has paid Social Security taxes for year after year finds, upon retirement, that (1) his monthly Social Security check fails to meet his old age needs and (2) if he tries to elevate himself above a poverty level by earning after-retirement income, he is penalized, through reduction in his monthly Social Security check, for attempting to maintain his self-respect and personal dignity.

To penalize a citizen for his effort to maintain his personal independence is as un-American as the Communist Manifesto. It establishes a system of enforced poverty by federal edict.

STATEMENT REGARDING TITLE XIX AND CHANGES PROPOSED BY H. R. 5710

This Association supports the intent of the proposed amendments to permit less rigid application of criteria used in establishing income eligibility for Title XIX benefits. This is commendable in that it recognizes the concept of self-help or family help, and does not deny a person benefits or reduce his benefits simply because he has limited financial resources.

Section 204. "The Federal Assistance in Meeting the Costs of Community Work and Training." This intent is commendable in that it helps the individual build self-reliance and self-respect.

Section 207. "Temporary Assistance for Migratory Workers." This proposal is commendable. However, this Association recommends that the legislation provide for development of this program in cooperation with and project administration by voluntary and private agencies, including the voluntary and private health insurance industries.

Section 225. "Advisory Council on Medical Assistance." This Association supports this section, but wishes to cite two significant changes that should be made in the make-up of the proposed council. One is that there should be a definite provision for meaningful representation from the private sector of medicine, since this sector provides most of the medical care under this program. The other change indicated is the deletion of the requirement for majority representation of consumers of health services. Physicians and providers of services are, by training, profession, knowledge and experience, best equipped to serve on this proposed council and it is illogical to say that they must, by law, constitute a minority.

Section 226. "Free Choice by Individual Eligible for Medical Assistance." Adoption of this section is essential. It is unethical for a physician to participate in any arrangement that denies free choice of physician on the part of the individual. Therefore, absolute free choice must be provided if the Title XIX program is to be construed as ethical.

ERRORS OF OMISSION IN H. R.

There are some major errors of omission in H. R. 5710, and the Committee is seriously urged to rectify these errors, which represent the failure of the Department of Health, Education, and Welfare to acknowledge serious defects in the existing Title XVIII and Title XIX programs, defects which repeatedly and conscientiously have been called to the Department's attention by the medical profession.

In fact, the Department has treated medicine's recommendations as a game. I call to your attention the attached Exhibit B, in which the Under Secretary of Health, Education, and Welfare, Mr. Wilbur J. Cohen, in referring to medicine's outline for improving these programs, states, "Four out of 11 is a pretty good batting average in any big league."

In the first place, the medical care of millions of Americans is not a ball game. It is a solemn and serious responsibility that only the Medical Profession can fulfill. A person's health, next to his life, is his most precious asset. Treatment of this responsibility in terms of a game is repugnant and distasteful, and indicates a lack of mature judgment.

If medicine's efforts to improve the Medicare and Medicaid programs to enable more meaningful physician-patient relationship and a more efficient and more feasible administration of these programs are to be treated as a game, the participation of physicians can hardly be expected to continue.

It is our sincere recommendation that the Committee on Ways and Means will see fit to amend Public Law 89-97 as follows:

1. Remove the requirement for three days of hospital care in order to qualify for extended care benefits. The present requirement is totally unnecessary, and is based on an artificial and false assumption that

(Continued on Page 687)

(Continued from Page 682)

a patient must be ill enough to require hospital care before he requires extended care.

2. Provide for the acceptance of a physician's statement of charges as a valid claim for reimbursement. The present requirement for a receipted bill works an undeserved hardship on patients. The Medicare program was presented to the American people as an "insurance program," yet there is no other insurance program, voluntary or private, that requires a beneficiary to provide a bill receipted by the physician in order for the beneficiary to be reimbursed for a valid claim. The present requirement is nothing more than needless red tape. It means that the physician must bill the patient, the patient pay the bill, the physician provide a receipted bill, and the patient then present the receipted bill in order to be reimbursed by Social Security.

If the physician accepts assignment, he must prepare the 1490 Claim Form, submit it to the Part B carrier, wait for the carrier to determine the reasonable and prevailing fee, accept 80 per cent of that fee from the carrier, prepare another statement in the amount of 20 per cent of that fee, and present that statement to the patient.

As of last January, only 15 per cent of the claims received by Ohio's major Part B carrier since July 1, 1966, were on assignment, while 85 per cent were in the form of receipted bills presented to the carrier by the patient.

This Association also urges the Committee to eliminate a major point of administrative delay and confusion in the Title XVIII program. This concerns the present practice of reimbursing hospitals for certain professional medical services with moneys from the Part B—Supplementary Medical Insurance Benefits. Hundreds of thousands, if not millions, of dollars in unpaid accounts, involving hospitals as well as physicians, have accumulated in this category because of the confusion that exists.

The solution is simple and highly practical. The issue can be resolved immediately by an amendment to provide that:

1. Part A payments may be made only for hospital services and may be made only to hospitals.
2. Part B payments may be made only on the basis of a statement for professional medical services submitted by the physician providing or responsible for the service rendered the patient with payment to be made directly to the patient or, on the patient's behalf, to the responsible physician.

Regarding Title XIX, it is respectfully requested that certain provisions be incorporated in this program.

It should be clearly provided that Title XIX funds may be used in programs that reimburse welfare recipients who pay for their own medical services. This would clarify HEW's unsubstantiated and clouded

EXHIBIT B

THE UNDER SECRETARY OF HEALTH, EDUCATION, AND WELFARE WASHINGTON, D. C.

February 23, 1967

Dear Sam:

Just a brief note to keep in touch with each other. I thought you would be interested to know that in the new social security bill that has been introduced, we have included four of the amendments which Mr. Harrison recommended in his letter of January 24 to Assistant Secretary Huit. They relate to physician certification in title XVIII and the following three items in title XIX—freedom of choice of physician and facility, administrative costs, and National Advisory Council.

Four out of 11 is a pretty good batting average in any big league.* I think it is evidence of the cooperation and free exchange of ideas and information which we hope will continue.

With best personal wishes,

Sincerely yours,
Wilbur J. Cohen
Under Secretary

Dr. Samuel R. Sherman
Chairman, Council on Legislative
Activities
American Medical Association
535 North Dearborn Street
Chicago, Illinois 60610

* Underlining added.

directive that (1) Title XIX funds may be used only for vendor medical payments and (2) federal matching funds will be withdrawn from programs that make medical care payments directly to welfare recipients. (See Exhibit C.)

Payment of the physician's usual, customary, and reasonable charges should be provided. At present, Title XIX programs provide full payment for all health care services except medical care.

The medical profession for centuries has freely delivered, without charge or at drastically reduced charge, professional care for the needy. More recently, government has, by law, assumed the responsibility for payment for the health care requirements of the needy. Now, the profession finds that the rapidly increasing numbers of persons covered by welfare programs represent a portion of the physician's practice so significant that he cannot, economically or in fairness to his other patients, continue

to provide a two-fold subsidy of such programs, one subsidy being through the payment of taxes to support the programs, one subsidy being through the payment of taxes to support the programs and the other being through the acceptance of reduced payments or no payments.

It must be emphasized that, when a patient has an agreement or contract that a third party will pay his medical expenses, the physician is not a part of or party to such arrangement.

This Association recommends that provisions be made to permit variations in eligibility and assistance standards in recognition of geographic and economic differences in living costs. While a recipient's needs in a high cost of living area may be identical with one's needs in a lower cost of living area, the former requires greater financial assistance in meeting his needs.

The determination and application of the variability factors should be left to the state agency administering the program.

One of the most significant recommendations this Association can make is that effective provisions be made for use of insurance carriers in Title XIX programs. The vast experience of this industry in the health insurance field should be utilized effectively. Provision of health care benefits through procurement of health and medical insurance policies through private and voluntary carriers would produce more efficient and more comprehensive use of the tax dollar. A vast and previously untapped source of personnel and experience would be brought into play in these programs.

It is an axiom that to get the best results, give the job to the experts.

Finally, we would comment on the considerable tax increases contemplated in H. R. 5710. The Social Security tax rate and tax base already border on the oppressive. The wage-earner is being taxed almost beyond the point of his endurance. The economic and actuarial danger signals are there for all to see.

It is the considered opinion of this Association that expansion of the present Social Security program and increasing benefits at this time, particularly since it will take several years to evaluate accurately the effects of recent amendments to the program, would be dangerous and would invite disaster.

The present program is replete with injustices, inconsistencies and imbalance. Rather than aggravate these conditions, now is the time to pause for a measurement, an evaluation, a review in retrospect. Sanity and equilibrium must be restored. The program suggested in Exhibit D appears to be a sound and logical solution.

I deeply appreciate your kind attention to this involved and detailed presentation.

The Ohio State Medical Association respectfully requests that this statement and the accompanying exhibits be presented to the House Committee on Ways and Means for inclusion in the official record of the hearings on H. R. 5710.

Sincerely,

L. C. Meredith, M. D.

President

Ohio State Medical Association

Attachments: Exhibits A, B, C, D

EXHIBIT C

Statement of The Council Regarding Ohio's Aid for Aged Programs and Titles XVIII and XIX, of Medicare

THE Ohio Department of Public Welfare provides Aid for the Aged recipients an extra \$3 a month to purchase coverage under Part B, Medicare, but not all recipients make this purchase. (About 90 per cent do.)

The Department's policy is that it will pay the first \$50 of medical expenses incurred by a recipient, after which Medicare will pay 80 per cent of what the Part B carrier determines to be the reasonable and prevailing fee. The Department further states that it will not pay the unsatisfied 20 per cent of the fee. If the patient has not purchased Part B coverage, the Department will pay 60 per cent of the physician's usual, customary, and reasonable fee for his services.

To enter a Part B Medicare Claim, the AFA recipient (just as any other Part B claimant) must provide the Part B carrier with a receipted bill or a 1490 claim form on which the physician accepts assignment. In accepting assignment, the physician agrees to accept what the Part B carrier determines to be the "reasonable and prevailing fee."

The AFA recipient has the alternative of either (a) furnishing the Department (or carrier) with a bill receipted by the physician or (b) a 1490 claim form on which the physician has indicated that he accepts, from the recipient, an assignment of the recipient's claim. By accepting such assignment, the physician is required, under Medicare law, to accept as his full fee whatever sum the Part B carrier deter-

mines to be the reasonable and prevailing fee, 80 per cent thereof to be paid by Medicare and not more than 20 per cent thereof by the recipient himself.

If the physician elects to refuse to accept assignment and directly bills the AFA recipient (or any other recipient) the physician is not required to accept as his full fee what the Part B carrier or any government agency may determine to be a reasonable and prevailing fee for the purpose of making payment to or on behalf of a recipient.

Under the alternate method of billing a Part B claim, namely, furnishing a receipted bill, the AFA recipient pays the physician the full amount of the physician's bill and then files with the Department (or Part B carrier) the physician's bill duly receipted, along with a 1490 claim form, requiring no assignment. The Part B carrier then reimburses the recipient directly, paying him 80 per cent of whatever amount the Part B carrier determines to be the "reasonable and prevailing fee."

The Department of Welfare discourages this alternate method because, the Department claims, this requires the AFA recipient to pay his medical expenses out of funds he is furnished by the Department for his day-to-day living requirements.

The acceptance by a physician of the AFA recipient's assignment of his Medicare claim, involving as it does an agreement by the physician to allow a government agency (Part B carrier) to decide what his fee should be, violates a fundamental policy of the Ohio State Medical Association, and it is therefore recommended that the physician refuse to accept any Medicare (Title XVIII) or Medicaid (Title XIX) assignment.

Further, the sending of a bill (for medical services to an AFA recipient) to any person other than the recipient himself — or his legal guardian — violates the "direct billing" policy as established by the Ohio State Medical Association. It is therefore recommended that the physician, in billing for services to AFA recipients, send his bill to the recipient (or his guardian) and to no one else.

To expedite, it is suggested that the bill include diagnosis, treatment, AFA health card number and medicare claim number.

This Association has recommended to the Ohio Department of Public Welfare that the following procedure be employed in the AFA program:

1. The physician mail or present the bill directly to the AFA patient.
2. The patient forward the bill to the Department, directly or through the County Welfare Department.
3. The Department pay the physician his usual, customary, and reasonable fee, directly or through the patient.
4. The Department provide the Part B carrier with evidence of payment, and the Part B carrier then would reimburse the Department 80 per cent.

The Department has stated that it cannot follow this plan. The Department also has stated that HEW has ruled that the Department cannot make direct payments to AFA beneficiaries to reimburse them for medical expenses and, if such reimbursements or any direct medical payments to patients are made, federal matching funds will be withheld.

HEW, in two meetings with OSMA in January, contended that federal law prohibits such direct payments to patients. OSMA, in these meetings, repeatedly requested copies of any such law. Our requests have been ignored.

Meanwhile, payment for Aid for Aged medical services, whether billed on Medicare form 1490 or directly billed, was suspended July 1, 1966, in a dispute over an HEW requirement that the Ohio Department of Public Welfare first must determine that all resources, including Medicare, had been exhausted before AFA payments can be made, and that Medicare status must be checked through the Part B carrier. The Social Security Administration at first contended that this was not a Part B function. This created a stalemate. In January, SSA agreed to permit Part B carriers in Ohio to screen AFA claims through SSA computers in Baltimore. For those claims in which the \$50 deductible has not been satisfied, the Department of Welfare will pay the first \$50, after which the claims will be referred to the Medicare Part B carrier, and will require (1) an itemized, receipted bill or (2) an assigned Form 1490. Estimated of the backlog in AFA medical care claims range from 50,000 to 100,000 claims, which now are being screened. This screening is expected to take several months.

In January, a Part B carrier, Nationwide Insurance Company, reported that only 15 per cent of Part B claims it had received in Ohio since July 1, 1966, were on assignment, compared with 24 per cent of Ohio claims assigned as of last September.

It is the position of The Council of the Ohio State Medical Association that:

(1) Physicians continue to bill directly all patients, including Medicare and Medicaid (Titles XVIII and XIX), and

(2) The U. S. Department of Health, Education, and Welfare must adhere to and honor the intent expressed by Congress when the Congress specifically and pointedly provided in the Medicare Act two methods of billing for professional medical services, namely, directly billing the patient or acceptance of assignment.

(Signed) L. C. MEREDITH, M. D.
President
Ohio State Medical
Association
1/26/67

(See next page for Exhibit D)

On Social Security . . .

Social Security has become a sacred cow that no politician can afford to criticize—as the reaction by Republicans and Democrats alike to President Johnson's proposed rise in benefits has again made clear. Yet there is much to criticize.

1—In the past fifteen years, maximum old-age benefits have doubled. *But* the maximum tax assessed on a worker's wages has quintupled.

2—Retired persons currently enjoy a bonanza. *But* youngsters currently entering the system are getting a raw deal.

3—The benefit scale in the law is designed to favor the relatively poor. *But* the law has important indirect effects that favor the well-to-do.

The first two facts have a common origin: the aging of the social-security program. At its start in 1937, many workers became taxpayers, no one a beneficiary. It was all intake, no outgo. As time passed, workers who retired began to qualify for benefits. But for some time, the number was so small that outgo still fell far short of intake, even though retired workers received benefits that were many times as large as the equivalent of the taxes once paid on their wages. This situation has been changing rapidly. From 1950 to 1965, the number of retired workers receiving benefits grew more than sixfold, while the number of taxpayers less than doubled.

Benefits and Taxes

To finance the excess payments to the growing number of retired, taxes assessed on wages have had to be raised repeatedly. As a result, the benefits promised younger workers are much smaller than the equivalent of the taxes paid on their wages.

The third fact—that social security has indirect effects that discriminate against the poor—is much more subtle. Note a few.

1—The poor generally begin working earlier than the well-to-do. So, on this score, they pay taxes for more years. Yet benefits, once eligibility is established, do not depend on number of years for which taxes are paid.

2—The well-to-do tend to live longer than the poor. They are therefore more likely to survive to receive benefits and also to receive benefits for more years. (This effect is partly offset by the greater value of survivors' benefits to the poor.)

3—Working wives get little for their taxes.

4—Men or women who do not pay taxes for enough quarters to qualify for benefits get nothing whatsoever in return for their taxes.

5—A man between 65 and 72 who works and earns more than a small amount per month loses part

or all of his social-security benefits. To add insult to injury, taxes are still assessed on his wages! Property income, on the other hand, whatever its amount, does not affect benefits received.

Clever Packaging

Though labeled "insurance," the system of old-age benefits is no such thing. It is a welfare program that transfers income from some to others—notably from the young, rich and poor, to the old, rich, and poor. Few of those who support the present system would favor either the structure of taxes by itself—a flat percentage tax on the first \$6,600 of earnings and a zero tax on higher earnings—or the structure of benefits by itself—indiscriminate benefits based on age, sex, marital status, and previous employment, with no attention to need. Tying the two together and labeling the combination insurance was a masterpiece of clever packaging.

In a recent article (*The Wall Street Journal*, Dec. 20, 1966) Prof. James Buchanan and Colin Campbell propose a sensible and ingenious method for converting present arrangements into a true insurance system—which could be voluntary—while at the same time fully honoring existing commitments. They propose that current liabilities—which they estimate at the staggering total of \$400 billion—be openly recognized, funded, and made an explicit charge on general tax funds and that the taxes imposed on younger workers be reduced to the level required solely to pay for the benefits they are being promised. The workers could then be permitted to purchase equivalent retirement benefits elsewhere if they so chose, without endangering the financial soundness of the government system. Their plan—and others for achieving the same objective—deserves prompt and serious consideration.

—Milton Friedman, "On Social Security,"

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Eligible Ohio Physicians Invited To Join Fifty Year Club

Eligible Ohio physicians who have not already become members, are invited to join the Fifty Year Club of American Medicine. President-Elect of the national club is Dr. Edward J. McCormick, 316 Michigan Avenue, Toledo, who is Past President of the Ohio State Medical Association, and Past President of the American Medical Association.

Membership fee is \$5.00, and this amount entitles the physician to a tie clasp and lapel button. Membership application should be sent to J. H. McCurry, M. D., Secretary, Cash, Arkansas 72421.



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Activities of County Societies...

First District

(COUNCILOR: PAUL N. IVINS, M. D., HAMILTON)

BUTLER

Dr. Clark Sleeth, dean of the West Virginia School of Medicine, was guest speaker for the March meeting of the Butler County Medical Society at the Elks Club in Hamilton. A social hour and dinner preceded the meeting.

Dr. Sleeth spoke on the topic, "How a Medical School Was Built from the Ground Up," giving an illustrated talk on the West Virginia school and its development.

HAMILTON

"Approach to the Diagnostic Evaluation of the Hypertensive Patient," was the topic for a panel discussion at the March 21 meeting of the Academy of Medicine of Cincinnati.

Dr. Thomas E. Gaffney, professor of pharmacology at the University of Cincinnati College of Medicine, was moderator. Participating as members of the panel were Dr. John H. Laragh, Columbia Presbyterian Hospital, New York City; and Dr. John H. Moyer, professor and director of the Department of Medicine, Hahnemann Medical College of Philadelphia.

The ninth annual Athletic Medical Conference was staged by the athletic advisory committee of the Academy on March 30 at the Princeton High School. Dr. Marvin McClellan was committee chairman in charge of the program.

Persons invited included physicians, athletic directors, coaches, educators, and other persons interested in athletic safety. The conference included the area of Adams, Brown, Butler, Clermont, Clinton, Highland, and Warren Counties, as well as Hamilton County.

Second District

(COUNCILOR: THEODORE L. LIGHT, M. D., DAYTON)

MONTGOMERY

Two researchers who are associate professors in the Tennessee Psychiatric Hospital and Institute at Memphis, spoke at the March 22 meeting of the Montgomery County Medical Society, where they discussed alcoholism and the research that is being done in that field. They were Dr. James D. Beard, and Dr. David H. Knott.

Third District

(COUNCILOR: FREDERICK T. MERCHANT, M. D., MARION)

ALLEN

Dr. William J. Ledger, instructor in the Department of Obstetrics and Gynecology at the University of Michigan Medical Center, was speaker for the

March 21 meeting of the Academy of Medicine of Lima and Allen County.

HARDIN

Dr. John Guyton, associate professor of physical medicine at Ohio State University, was principal speaker at the March 14 meeting of the Hardin County Medical Society at the Hardin Memorial Hospital in Kenton. He discussed various phases of physical medicine programs available both at medical training centers and at other hospitals. Of the seven forms of physical medicine used at University Hospitals, he said, six are available at Hardin Memorial.

Fourth District

(COUNCILOR: ROBERT N. SMITH, M. D., TOLEDO)

DEFIANCE

On Wednesday evening, May 24, Dr. Charles L. Hudson, Cleveland, President of the American Medical Association, will give an address at Schomburg Auditorium, Dana Hall, Defiance College under the cosponsorship of the Defiance County Medical Society and Defiance College.

The time is 8:00 P.M. and the subject will relate to the challenge to the medical profession in the current society. The general public is invited.

Dr. Hudson is scheduled to remain in Defiance for an appearance on Thursday morning, May 25, on the Defiance College Forum for an address to the students on Careers in Medicine.

Fifth District

(COUNCILOR: P. JOHN ROBECHER, M. D., CLEVELAND)

CUYAHOGA

The Academy of Medicine of Cleveland was co-sponsor of a program on March 15, entitled "Computers and Physicians," or the role of modern information processing in medical practice.

Those who participated in the program and the phase of subject matter covered were the following:

Dr. Richard P. Levy, "Various Applications for the Computer in Medicine Today."

Dr. Maxine R. Cammarn, "Computer Processing of Medical Records on Ambulatory Patients."

Dr. D. A. Lindberg, "Computer-Based Reporting of Laboratory Data."

Alvin Goldwyn, "Selective Dissemination of Medical Information."

Sixth District

(COUNCILOR: EDWIN R. WESTBROOK, M. D., WARREN)

SUMMIT

"The Importance of Medical Political Action Committees" was the topic for discussion at the April 4 meeting of the Summit County Medical Society in the

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Children's Hospital auditorium, Akron. Speaker was Dr. Frank H. Mayfield, Cincinnati, president of the Ohio Medical Political Action Committee (OMPAC).

TUSCARAWAS

Featured speaker at the April 5 meeting of the Tuscarawas County Medical Society and Auxiliary was Dr. Edward Annis, Past President of the American Medical Association. The meeting was held in the Dover high school auditorium.

At a meeting on March 8, the Society went on record endorsing fluoridation of water systems in the county if deficient in fluoride.

Seventh District

(COUNCILOR: SANFORD PRESS, M. D., STEUBENVILLE)

BELMONT

Continuing with its policy of presenting native Belmont Countians as program speakers for 1967, the Belmont County Medical Society invited Dr. Conn Covert, of Warren, to speak at the March 16 meeting. His topic was "Bronchitis, Nemesis of Modern Man."

Tenth District

(COUNCILOR: RICHARD L. FULTON, M. D., COLUMBUS)

FRANKLIN

The Academy of Medicine of Columbus held a meeting at the Neil House on March 21, preceded by social hour and dinner.

The program was presented in two sections. The Columbus Society of Anesthesiologists presented as speaker Robert Gardier, Ph. D., who discussed "Cyclopropane and Catecholamine Metabolism."

The Central Ohio Academy of General Practice presented a discussion on the subject, "Computers in Medicine." Principal speaker was Robert C. Chase, chemical engineer and associate of the Division of Biometrics, Department of Preventive Medicine, Ohio State University.

State Medical Board of Ohio Issues Ohio Licenses

Results of the examinations conducted by the State Medical Board of Ohio on December 14-16, 1966, were considered by the Board at a meeting held on January 24.

Certificates to practice medicine and surgery were awarded to 41 graduates of schools of medicine, and 41 graduates of Osteopathic schools will receive certificates to practice osteopathic medicine and surgery.

In the limited branches, 11 persons were awarded certificates to practice physical therapy, two to practice mechanotherapy, 25 to practice chiropractic, 12 to practice massage, and two to practice cosmetic therapy.

Highest grade in the examinations for doctors of medicine was made by Denzil Hathway, Cleveland, a graduate of the University of Birmingham, England, with an average of 92.3 per cent.

Second highest grade was made by Rafael G. Belliard, Dayton, a graduate of the University of Santo Domingo, Dominican Republic, with 92.0 per cent; and third high went to Joseph R. Novello, of Lorain; a graduate of the University of Michigan Medical School, whose average was 90.1.

At the same meeting the Board also issued certificates to 43 doctors of medicine to practice in Ohio, through endorsement of their licenses to practice in other states which have reciprocity with Ohio, or through examination by the National Board of Examiners.

Dr. Lee R. Sataline, director of medical education at Toledo Hospital, was keynote speaker at the 46th annual convention of the Ohio Dietetic Association, meeting recently in Toledo.



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PHYSICIAN AND HOSPITAL EQUIPMENT

Ad Astra

William Kerr Allsop, M. D., Youngstown; Jefferson Medical College of Philadelphia, 1915; aged 74; died March 1; member of the Ohio State Medical Association and the American Medical Association; past president of the Mahoning County Medical Society. A practitioner of long standing in Youngstown, Dr. Allsop specialized in surgery. In addition to his professional affiliations, he was a member of several Masonic bodies, the Elks Lodge, and the Christian Church. Surviving are his widow, a daughter, and a son.

William Simmons Baldwin, M. D., Perrysburg; Western Reserve University School of Medicine, 1901; aged 88; died March 15; former member of the Ohio State Medical Association; Fellow of the American College of Physicians. A native of Lorain, Dr. Baldwin returned there to practice after receiving his medical training. A specialist in pediatrics, he retired in 1949 and moved to Perrysburg. He was a member of the Methodist Church and the Rotary Club. Survivors include his widow, a daughter, and a son, Dr. Allan Baldwin, of Athens; also a sister.

Joseph A. Colla, M. D., Youngstown; State University of New York at Buffalo, School of Medicine, 1925; aged 72; died March 7; member of the Ohio State Medical Association and the American Medical Association. A resident of Youngstown for some 60 years, Dr. Colla practiced there for 41 years and served as deputy coroner for Mahoning County. He was a veteran of World War II, having served in the Army Medical Corps. Among affiliations, he was a member of the Catholic Church, the Knights of Columbus, and the Knights of St. John. Survivors include his widow, three daughters, and four sisters.

Douglas Deeds, M. D., Golden, Colorado; University of Cincinnati College of Medicine, 1934; aged 58; died October 14 in Laguna Beach, Calif. Dr. Deeds practiced for a number of years in Denver, Colorado.

P. Michael Edelman, M. D., Milford; State University of New York, Downstate Medical Center, 1958; aged 37; died January 2 in a plane crash. Dr. Edelman's practice was in the field of internal medicine. He was on the faculty of the University of Cincinnati College of Medicine and on the staff of Cincinnati General Hospital.

Richard Neal Fluent, M. D., Cleveland; Western Reserve University School of Medicine, 1921; aged 71; died December 5; former member of the Ohio State Medical Association. Dr. Fluent's practice was primarily in the Cleveland area.

Earl Bernard Gerlach, M. D., West Palm Beach, Florida; University of Cincinnati College of Medicine, 1911; aged 77; died December 6. Dr. Gerlach formerly practiced in Huntington, W. Va., before he retired and moved to Florida.

Albert John Gerteis, M. D., Lakewood; Ohio State University College of Medicine, 1928; aged 78; died March 4; former member of the Ohio State Medical Association and the American Medical Association. Dr. Gerteis was a practitioner of long standing in the Lakewood area. A sister survives.

William James Jend, Sr., M. D., Detroit; Cleveland-Pulte Medical College, 1902; aged 90; died December 14. Available records indicate that Dr. Jend moved to Detroit early in his professional career.

Thomas Stephenson Miller, M. D., Maumee; Ohio State University College of Medicine, 1933; aged 66; died March 11; member of the Ohio State Medical Association, the American Medical Association, and the American Academy of General Practice. Dr. Miller devoted many years to practice in the Maumee area of Lucas County.

Emmett J. O'Malley, M. D., Cleveland; Georgetown University School of Medicine, 1931; aged 61; died March 17; member of the Ohio State Medical Association, American Medical Association; Radiological Society of North America, and the American College of Radiology; diplomate of the American Board of Radiology. Dr. O'Malley moved to Cleveland after serving in the Army Medical Corps during World War II and formerly practicing in Buffalo, N. Y. He was chief radiologist at St. Vincent Charity Hospital. Among survivors are his widow, a son, three daughters, and a sister.

Crawford Francis Pope, M. D., Cardington; Ohio State University College of Medicine, 1932; aged 59; died January 27; former member of the Ohio State Medical Association. Dr. Pope's practice in several areas of Ohio extended over more than 30 years. He is survived by his widow, a son, and a sister.

Louis George Ralston, M. D., Niles; Western Reserve University School of Medicine, 1940; aged 52; died March 14; member of the Ohio State Medical Association, the American Medical Association, American Academy of General Practice, Aerospace Medical Association, and the American Society of Abdominal Surgeons. A practicing physician in Niles for about 20 years, Dr. Ralston was active in community affairs; was a former president of the local board of education and a member of the

(Continued on Page 702)

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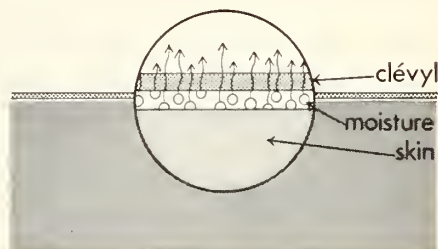
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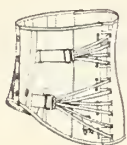
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Presbyterian Church. Dr. Raymond Ralston, also of Niles, is a brother. Other survivors include his widow, a son, two daughters, and another brother.

Franklin C. Reutter, M.D., Valley City and Medina; Eclectic Medical College, Cincinnati, 1928; aged 66; died March 14; member of the Ohio State Medical Association and the American Medical Association. Dr. Reutter began his practice in Spencer, and, after taking additional training, established an office in Medina where he specialized in the eye, ear, nose, and throat field. A member of the Lutheran Church, he is survived by his widow, a daughter, a son, five sisters, and a brother.

Harry Joseph Riemer, M.D., Cleveland; Indiana University School of Medicine, 1930; aged 62; died March 25; member of the Ohio State Medical Association and the American Medical Association. A Cleveland physician for 33 years, Dr. Riemer was associated in recent years with the Veterans Administration Hospital there. Among affiliations he was a member of the Temple and of B'nai B'rith. Surviving are his widow, a daughter, a son, two brothers, and a sister.

Guy O. Rowland, M.D., Alliance; Cleveland-Pulte Medical College, 1901; aged 94; died on or about March 15; member of the Ohio State Medical Association and the American Medical Association.

Dr. Rowland began his practice in East Palestine, but moved to Alliance early in his career and practiced there many years. He was former health commissioner of the city and held the title of emeritus health commissioner.

George W. Smeltz, M.D., Atlantic City, N. J.; Ohio Medical University, Columbus, 1907; aged 82; died January 4, former member of the Ohio State Medical Association (last membership in 1913). A former practitioner in Pittsburgh, Dr. Smeltz was making his home in Atlantic City in recent years.

Clark County Society Donation Memorializes Dr. Platter

The Clark County Medical Society recently made a donation of \$100 to Ohio Wesleyan University, Delaware, as a memorial to Dr. Herbert M. Platter. The memorial citation specifically refers to "the many years of fine services rendered by Dr. Platter to the Ohio State Medical Association," and further commends his contributions toward "the status of the health and welfare of the State of Ohio."

Dr. Platter, an alumnus of Ohio Wesleyan and a Past President of the Ohio State Medical Association, died on November 4, 1966, after some 48 years as secretary of the State Medical Board of Ohio.

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Policy Statements

REGARDING

GOVERNMENT MEDICAL CARE PROGRAMS

SECTION I

(Section II will appear in the June issue, OSMJ)

Developed by the
Ohio State Medical Association Committee on Government Medical Care Programs
and Approved by
The Council, February 18-19 and March 18-19, 1967

Ohio State Medical Association

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May 1, 1967

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TENTH—RICHARD L. FULTON, M. D., COLUMBUS
ELEVENTH—WILLIAM R. SCHULTZ, M. D., WOOSTER

Dear Member:

In the succeeding several pages you will find an explanation of the scope and function of several of the Government Medical Care Programs with which you deal or with which your patients are involved. Following the explanation of each of the programs is a delineation of O.S.M.A. policy with regard to that program.

The Committee on Government Medical Care Programs developed both the explanatory material and the policy statement recommendations which were confirmed by The Council in February and March. The Council of the Association feels that this information is most important. On their behalf, I recommend that you tear-out this section of your Journal and file it with other important reference material, but first, read it. I think that you will find that the information is informative and that the policy statements will aid you in making your personal judgment as to your relationship to the various programs.

In succeeding issues of The Journal, additional material with regard to Government Programs will be presented in special tear-out reports similar to this one. Please look for these and file them with this original statement. I would suggest that you purchase a three-ring notebook in which to file your material.

Sincerely,

L. C. Meredith, M.D.
President

LCM:gd

Listed in the following paragraphs are the Government Medical Care Programs which are considered in this report. Each program is presented with an explanation of its activities and functions. Following this explanation are listed the policy statements as approved by The Council. Because of the length of the report, it has been divided into two sections. Section II will appear in the June issue of *The Journal*. The background information presented represents an explanation of the program as it is, not necessarily as OSMA feels that it should be. Therefore, the reader should not consider the explanatory information as representative of OSMA policy.

General Policy Statement

REGARDING

GOVERNMENT MEDICAL CARE PROGRAMS

The following general statement of policy with regard to all Government Medical Care Programs was subsequently adopted by The Council.

The Council of the Ohio State Medical Association recognizes the responsibilities of members of the medical profession as a central factor in providing adequate medical and health care to all segments of the population.

Any program or efforts to provide such care should be designed to augment and complement the availability of sound medical and health care in a given community. The plan defeats its purpose and creates a negative community situation if it uproots, disrupts or brings about termination of existing services and facilities.

To that end, constructive criticism never should be misinterpreted or misrepresented as unfeeling opposition or obstruction, but rather as a method of achieving an improved and equitable condition that best serves the interests of the community's residents.

It must be emphasized that any program must take medical and health care to the people, rather than remove it from easy accessibility.

Whether any proposed project be multi-community or multicounty, in order to achieve positive goals, the planning, establishment and development of the project must be carried out according to the following concepts:

1. The medical profession of each community in the overall area must be initially,

permanently, and effectively involved from the beginning and on a policy-making level as voting members.

2. The health care needs of each community must be clearly established, and it must be determined that the needs established are realistic.

3. Rather than expend large sums of money for the construction of larger demonstration health centers, adequate funds should be made available for the addition to and enhancement of local facilities already in operation. These facilities may be single or multicounty.

4. Evidence must be submitted to the OSMA Council that an honest attempt has been made to utilize and coordinate all local resources, private, voluntary, and public health before government assistance is requested.

5. The creation or expansion of a core facility shall in no way be binding upon a physician to refer his patient to that facility.

6. The operation of any regional or county health service center shall not infringe upon the private practice of medicine.

7. The use of welfare and other government funds as regards patient and health care should be based on helping those who need help by providing them with funds to pay for the medical and health services they require.

8. These projects shall in no way be developed, operated, or influenced in a manner which could lead to a government controlled system of medical practice.

Appalachia and Demonstration Health Facilities (Sec. 202, Appalachia Act)

BACKGROUND INFORMATION

The health needs of Appalachia can best be met by providing more services, not just buildings, to the residents of economically depressed areas. It is recommended that these services be provided through a program for comprehensive health care in the medical service areas in which Appalachian demonstration health facilities are developed.

These conclusions were forwarded to the Appalachian Regional Commission in a report from its Health Advisory Committee the first week of March 1966. The Health Advisory Committee was created by the Commission in October 1965. It is chaired by Paul Miller, President of West Virginia University, and consists of 12 State and 12 Federal appointees. The Committee has been considering the most effective ways for developing "multicounty demonstration health facilities" as called for in Section 202 of the Appalachian Regional Development Act of 1965.

In its deliberations, the Committee particularly considered shortages in health manpower, and methods of organization and financing of health services. The need for more, and in some cases differently trained, health personnel in all categories was a major finding. It was recommended that regional institutions of higher learning, including medical schools and schools of public health, be involved in the development of these demonstration health facilities, since one of their primary responsibilities is the training of health manpower.

The Committee's report urged coordination and integration of all aspects of health services, public and private, preventive, curative and restorative, in the interests of efficiency and better patient care.

Such demonstrations also call for the organization of health services by natural geographic regions that are determined by location of populations, trade lines and health resources, rather

than by traditional political jurisdictions. This means that some communities will have to work together that previously have not and that communities that are more self-sufficient and ready for expansion and improvement of health services may have to invite and accept into the purview of their health program areas that might otherwise remain isolated and deprived.

It also stated that, in an area where from 25 per cent to 60 per cent of the families have incomes of under \$3,000 per year, some form of operating subsidy will probably be required for a considerable period if all of these families are to receive comprehensive health services. It pointed out the futility of building hospitals and clinics without first making arrangements for adequate staffing and realistic financing of operations.

Finally, the report emphasized the importance of personalized services, closely related to the patient's environment. Data on the whole Appalachian region, and detailed data on Martin County, Kentucky, provided by the U. S. Public Health Service, served to illustrate many of these points.

Congress set up the Appalachian development program as a means of stimulating economic growth in this depressed area. The area affected includes portions of the States of Alabama, Georgia, Tennessee, South Carolina, North Carolina, Kentucky, West Virginia, Virginia, Maryland, Pennsylvania, Ohio, and New York.

The Appalachian Regional Commission and the Health Advisory Committee will hold a series of Appalachian Regional Health Conferences during March, April, and May of this year. The University of North Carolina has received from the Milbank Memorial Fund a development grant not to exceed \$7,500 to assist it in this effort. These Regional Conferences will acquaint practicing physicians and dentists,

public health officers, educators, and interested lay individuals in the Appalachian region, with the Committee's conclusions on demonstration health facilities and will seek to learn from people working in the area some of the particular problems of their section of Appalachia.

The first of these meetings was held on March 17 and 18 in Pine Mountain, Georgia, and was attended by participants from Alabama, Georgia, North Carolina, South Carolina and Tennessee. The second meeting was held on April 21 and 22 in Charleston, West Virginia; and, the third meeting is scheduled in Pittsburgh, Pennsylvania, May 5 and 6.

Sec. 202. (a) In order to demonstrate the value of adequate health and medical facilities to the economic development of the region, the Secretary of Health, Education, and Welfare is authorized to make grants for the construction, equipment, and operation of multicounty demonstration health facilities, including hospitals, regional health diagnostic and treatment centers, and other facilities necessary to health. Grants for such construction (including initial equipment) shall be made in accordance with the applicable provisions of Title VI of the Public Health Service Act (42 U.S.C. 291-291z) and the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963 (77 Stat.

282), without regard to any provisions therein relating to appropriation authorization ceiling or to allotments among the States. Grants under this section shall be made solely out of funds specifically appropriated for the purpose of carrying out this Act and shall not be taken into account in the computation of the allotments among the States made pursuant to any other provision of law.

(b) No grant under this section for construction (including initial equipment) shall exceed 80 per centum of the cost of the project. Not to exceed \$41,000,000 of the funds authorized in section 401 shall be available for construction grants under this section.

(c) Grants under this section for operation (including equipment other than initial equipment) of a project may be made up to 100 per centum of the costs thereof for the two-year period beginning on the first day such project is in operation as a health facility. For the next three years of operations such grants shall not exceed 50 per centum of such costs. No grants for operation of a project shall be made after five years following the commencement of such operations. Not to exceed \$28,000,000 of the funds authorized in section 401 of this Act shall be available for operating grants under this section.

POLICY STATEMENTS

It was noted that the recommendations of the Appalachian Liaison Committee, chaired by Dr. Tschantz, had been approved at the December 10-11, 1966 meeting of The Council.

In view of the policy previously established, and further deliberations of the Committee, The Council approved its recommendations as follows:

Preamble

"It must be admitted that neither organized medicine, the states, nor the various communities have accepted the challenge of leadership in this vital area, thus creating a gap or vacuum into which the federal government is moving. The process of creative federalism is already at work. The medical profession has an innate responsibility in the implementation and operation of the facilities, and with the

acceptance of these responsibilities should be entitled to the privilege of adequate representation on national, state, and local bodies which determine policy, authorize expenditures, and direct the various phases of these public health projects." (From White Paper on Appalachia—1966, West Virginia State Medical Association)

Be it Resolved:

1. That a representative (practicing physician) from each County Medical Society included in the plan of the Ohio Valley Health Service Foundation, Inc., be a voting member of the Board of the Ohio Valley Health Service Foundation and that, in the future, any areas engaged in Demonstration Health Facility Planning included at the top level of organization, a representative (practicing physi-

cian) from each county medical society involved in the plan.

2. Small county medical societies be allowed to combine into multicounty societies so that more medical leadership be provided in planning groups.

3. That legislation be sought to combine local county health departments into multicounty health departments so that more services

may be given and this kept on a local, rather than a national level.

4. That recommendations of the OSMA Appalachian Liaison Committee, approved by The Council in December, be vigorously supported and the plans of the Ohio Valley Health Service Foundation, Inc. be carefully scrutinized in light of these recommendations so that OSMA policy will be adhered to.

For supplemental OSMA Statement on Appalachia, refer to "General Policy Statement" on page 3.

Bureau of Vocational Rehabilitation

BACKGROUND INFORMATION

The Bureau of Vocational Rehabilitation of the State Board of Education is a public service agency. It has a Rehabilitation Section which provides for the vocational rehabilitation of the physically and mentally disabled other than legally blind. It also has a Disability Determination Section.

Disability Determination Section

Since 1954, the Ohio Bureau of Vocational Rehabilitation has been responsible for determining the disability of Ohio applicants for Social Security disability benefits. Professional claims examiners, assisted by medical consultants, make recommendations as to disability status to the Bureau of Old Age and Survivors Insurance. Disabled persons in need of rehabilitation are referred to the Rehabilitation Section of the Bureau of Vocational Rehabilitation. The program is financed entirely by the Social Security Agency.

Rehabilitation Section

The Bureau of Vocational Rehabilitation has seven regions and 17 district offices in Ohio staffed by supervisors and rehabilitation counselors. Each district office has a medical consultant.

A medical advisory committee of nine outstanding physicians advises on medical procedure.

To be eligible, a person must reside in Ohio, have a diagnosable disability, have a substan-

tial vocational handicap, and be presumed to be able to become employed.

Referral may be made in writing or by requesting a visit by the counselor.

The following services and materials are provided in order to carry out the objectives of the agency:

1. Diagnosis
2. Counseling and planning
3. Personal adjustment training
4. Vocational training
5. Training supplies and books
6. Physical restoration
7. Maintenance and transportation
8. Occupational tools and equipment
9. Placement
10. Follow-up on the job

In 1965, 2,704 patients were rehabilitated.

There are no age limitations but practically all rehabilitants are over 16 years of age. The greatest number was in the 20-34 age group.

The greatest cause of disability, 32.4 per cent, was orthopedic deformities.

Educational institutions were the greatest source of referral at 17.9 per cent of the total. Physicians referred only 8.2 per cent of patients although it was recognized that the physician may have been personally responsible

for original referral in many cases otherwise recorded.

In 1965, 5,758 services were rendered to clients. Of these, diagnosis, evaluation, and physical restoration services totaled 3,567. The remainder consisted of training, equipment, and other.

Annual earnings of clients before rehabilitation in 1965 were \$1,218,984 and earnings after were \$8,243,248.

Rehabilitants per 100,000 population (including the blind) were 29 in Ohio compared to 70 in the United States giving Ohio a rank of 52 among the 54 states and territories.

The Federal Government matches state funds in the amount of 75 to 25. The State of Ohio has never appropriated the funds to match Federal funds. The Bureau of Vocational Rehabilitation spent \$1,091,954 of state funds in 1965. If appropriations continue at the same level, the state will lose \$8,855,027 in Federal Funds. The staff of the Bureau of Vocational Rehabilitation believes that many more persons could be rehabilitated if more state funds were available.

The Bureau of Vocational Rehabilitation has a fee schedule which is not published for general distribution. Most fees submitted are within the range but near the maximum. The Subcommittee, after review of the schedule, was of the opinion that in general fees are adequate. The fee schedule is approved by the medical advisory committee.

The voucher for payment has a statement on

civil rights compliance. It is printed as a matter of information below the signature. Membership in the Ohio State Medical Association is regarded as prima facie evidence of civil rights compliance.

The State Auditor will not pay bills until a receipt is produced. The patient may give a promissory note or pay the physician and be reimbursed, or the physician may be paid directly by the state agency.

An excellent pamphlet entitled "Information for Referring Agencies and Physicians" is published by the Bureau of Vocational Rehabilitation. This has been distributed on one occasion to the membership of the Ohio State Medical Association.

It should be noted that at present there is a Governor's Council on Vocational Rehabilitation whose objective is formation of a plan to assure that by 1975 all patients needing rehabilitation services will receive them.

The Subcommittee believes that the program of the Bureau of Vocational Rehabilitation has a major medical emphasis and that it should be the concern of all Ohio physicians. The objectives of the program clearly follow the intent of the medical profession aimed at the management of the rehabilitation of the patient rather than the treatment of disease.

The Subcommittee was of the opinion that the Bureau of Vocational Rehabilitation is operating its agency on principles which should in general have the support of the Ohio State Medical Association.

POLICY STATEMENTS

Regarding the program of the Bureau of Vocational Rehabilitation, it was resolved:

1. That an educational campaign be conducted among physicians by the Ohio State Medical Association to encourage referral of patients for rehabilitation.

2. That the Ohio State Medical Association support an increased appropriation by the State for the Bureau of Vocational Rehabilitation.

3. That the Ohio State Medical Association have a close continuing relationship with the Bureau of Vocational Rehabilitation through the Committee on Governmental Medical Care Programs.

4. That the Ohio State Medical Association pursue the adoption by the Bureau of Vocational Rehabilitation of the principle of payment of the physician's usual, customary, and reasonable fees.

5. That various reports regarding patients being treated under this program be made from the attending physician to the Field Medical Consultant and not to lay administrators, in order to protect confidentiality of physician-patient relationships.

6. That an appeal be made to the Bureau requesting that a physician be appointed to the Ohio Council on Vocational Rehabilitation.

Crippled Children's Program

BACKGROUND INFORMATION

At the present time the State Crippled Children's Service, provides care for children with certain handicaps of such a nature as to constitute major barriers to the child's total adjustment; to those parents who need help in paying for this medical care and to those members of the state who are under 21 years of age and living in Ohio.

At present the Crippled Children's Service is a Bureau in the Division of Health and Rehabilitation Services in the Ohio Department of Welfare. In this connection the Welfare Department is charged with the responsibility to "provide care of all kinds which the board deems for the best interests of any child the board finds in need of public care or service; provided such care shall be provided by the board of its own means or through other available resources, in such child's own home, in the home of a relative, or in a certified foster home, school, hospital, convalescent home, or other institution, public or private, within or outside the county or state." There has been legal authority established for this in the Revised Code of the State of Ohio.

Services for Crippled Children

The Crippled Children's Service has a Medical Director who is appointed by the chief of the Division with the approval of the Director of Public Welfare. This Medical Director is a Board certified pediatrician employed full time to serve in that capacity. All medical decisions are made by the Medical Director. All decisions are made with reference to what appears to be in the best interest of the child. The Medical Director consults with the managing physician and the Social Nursing Consultant. In addition the Medical Director consults with the Director of the Department of Public Welfare and the Medical Advisory Board of the Children's Bureau. The Medical Director is responsible for the approval of physician specialists and other specialists for services for children. This includes the development and distribution of fee schedules. The eligibility of a child in the program belongs to the Medical

Director but is usually delegated to the Social Service Director, and the Social Service Consultants.

It is the responsibility of these people to see that the proper physicians and services are brought together for the benefit of the child being treated.

Financing

At the present time the money for this program comes under three sources. First, .05 mill of county tax money, or 35 per cent of the total, is allocated to the State from each county participating in the program. Second, \$700,000.00 has been allocated by the State Legislature which is allocated according to the child population of each county and represents 15 per cent. Third, under Title 5, of the Federal government, approximately 50 per cent of the money is allocated.

Until the last two years all of the money allocated to this program was never spent in each year. At the present time \$4 million is being used annually for the program. Ohio represents the fourth lowest state in the Union in its spending for Crippled Children's programs. Other agencies dealing with children are Aid to the Dependent Child and Title 19. At the present time there are approximately 8,000 children in the program. The annual hospitalization costs represent approximately 2.5 million of the entire \$4 million being spent.

Method of Operation

At the present time children with crippling defects are found from whatever source available. Depending upon the crippling defect, and in the beginning of this service these were almost all orthopedic, the child is then referred to an appropriate specialist who makes application for the child to become a part of the service. Application is made on Form CC5, and sent to the Bureau of Crippled Children's Services, 527 South High Street, Columbus, Ohio 43215. Investigation follows by the Social Service and Nursing Departments. If the child is then found eligible for the program, authorization is granted and a number as-

signed. The service contracted for is performed by an accredited physician in an accredited institution.

All sorts of medical services are provided including dental, etc., and are then followed up by a rehabilitative type care and rehabilitative educational extension of the care. The whole program being aimed at eventual total rehabilitation of the child to a useful healthy state. Such services include shoes, braces, appliances, casts, surgery, dental work, eye and hearing work, speech therapy, physical therapy, occupational therapy, and educational help. The program has been a total rehabilitation type program.

In addition to this some clinics have been established primarily in southern and southeastern Ohio for children with orthopedic, plastic, cardiac, hearing, and visual defects.

Up to now the primary physician in treating the child was whoever submitted the appli-

cation for therapy and everyone else included in the program was considered a consultant to this physician.

Fees

The fees for the cost of institutions such as hospitals is based upon a registered per diem cost with the State Division of Business Administration.

The fee schedule for professional services is adopted annually by the Crippled Children's Service on recommendation of its Medical Advisory Board. The Medical Advisory Board is made up of a number of specialists from about the State and is based on the availability of funds.

At the present time all vendors of service are instructed to mail all bills to the Division of Business Administration. These bills are made out to the State Department of Public Welfare and sent to the Division of Business Administration in Columbus.

POLICY STATEMENTS

1. In the opinion of The Council the Crippled Children's program, under the present direction of Dr. Elizabeth Aplin, has expanded appropriately to meet the challenge of need, and is doing a fine job.

2. It is noted that the total program is a constructive one, devoted primarily to the acceptance of children who have a reasonable outlook of some degree of complete rehabilitation, rather than just care of disabled children. It is not that the care of disabled children is unrealistic, but that this care should remain the province of other departments and the primary aim of rehabilitation of children remain with the Crippled Children's Service.

3. At the present time, short and long lasting illnesses or handicaps that threaten the financial future of the family, fit into the program. These basic reasons for accepting children into the Crippled Children's Service appear appropriate and should be continued.

4. Since the care of the child is the responsibility of the physician and the child's parents, it would appear appropriate to have the parents of the patient request help from the Crippled Children's Service. In this way the

contract for medical and monetary assistance would reside properly with the parents since they are the ones seeking assistance. In this way two separate contracts would be consummated. The first, would be a contract between the child's parents and the physician for the rendering of medical care. The second, would be a contract between the child's parents and the Crippled Children's Service for monetary assistance in paying for this care.

5. At present resident physician care for children is permitted in the hospital or clinic providing the resident and the child are under the direction of an accepted specialist. Inasmuch as these patients are not charity patients. The Council sees no reason to alter this, providing the patient be treated properly as a private patient of the physician in charge.

6. At present no clinic or hospital as such is granted the right to care for crippled children in this program. This decision is based on the fact that there may be changes in resident and/or institutional physicians and therefore continuity of care may be lost. The Crippled Children's Service does not pay clinics for the care of its patients. The child is considered the

private patient of the doctor approved by the program for the patient at the time of the acceptance of the application. This arrangement appears satisfactory and should be continued.

7. In setting up a budget for the family in question concerning the monetary help they need, the resource of the family, including health insurance that they may have, is taken into account. Then the estimate of the total cost is made and the Crippled Children's Service adds to this the amount of money estimated to be needed to complete the rehabilitation. Since the monetary contract for help should be made between the parents of the patient and the Crippled Children's Service, it would seem appropriate for the payment to go back to the parents and thence to the physician. It is thought that this is a proper procedure both from the contract arrangements standpoint and the fact that the parents would then realize the value of the service that is being paid for.

8. At present all medical, hospital, and other fees are paid on a contract basis. Each Ohio hospital is required to submit an annual audit to the State Department of Health. This report is adjusted to take into account the field audit made by the Bureau of Workmen's Compensation. A per diem cost is then certified by the Health Department to the Bureau of Motor Vehicles and to the State Department of Public Welfare. This then becomes the daily payment that the service will render to hospitals. Physicians are paid on a predetermined fee schedule. This has been necessary in the past because of the monetary limits set upon the program. However, since hospitals are paid on a going daily rate which in effect should be their usual daily rate for the case of any patients, then it would seem reasonable for physicians to be paid their usual fee rather than on a fee schedule. The Council recom-

ments that the necessary money be appropriated to the program to run it on a sound fiscal basis and accomplish all its payments on the usual fee and usual cost basis.

9. Up to now and including the present the Crippled Children's Service has operated some clinics throughout the State. These have been primarily in eastern and southeastern Ohio. They are now in the process of being evaluated and it is the opinion of this committee that such mass screening as it is presently carried out, defeats the purpose of the program. Since the program has propagated the idea that the child is the private patient of a physician, such mass clinic evaluation by any specialists would appear to be defeating the program. It is recommended that this type of service be discontinued unless specifically desired and approved by the county medical society.

10. The scope of the program in the past has been total rehabilitation to whatever degree is possible. It would seem reasonable at some point in the progress of events, that relinquishing the child in question either to an educational system, prearranged, or to a vocational rehabilitation program, prearranged, would satisfy the ends of this program and then would relieve the Crippled Children's Service of further financial involvement so that their available money could be spent on another child entering the program.

11. At present the crippled children's program takes children to the age of 21. Since aid for the totally disabled begins at age 18, it would appear appropriate for the Crippled Children's Service to refer all of those children who appear to be totally disabled to that service at that age instead of carrying them on until they are 21 years of age. This would effect a monetary savings for this service and avoid duplication.

Heart Disease, Cancer, and Stroke Program (P. L. 89-239)

BACKGROUND INFORMATION

Preamble

Among important measures dealing with Medicine, the 89th Congress enacted Public Law 89-239 authorizing federal grants to aid in planning and operating demonstration projects for the establishment of regional medical programs in the fields of heart disease, cancer, stroke, and related diseases. This legislation, considered by many to have greater significance and potentiality than Medicare, was implemented on the basis of recommendations of a President's Commission (widely known as the DeBakey Report). Several amendments offered by an Advisory Committee of the AMA were accepted before final adoption by Congress.

This bill aroused expressions of disapproval from various segments of the Profession. Some felt that its stated intent was too vague. The wisdom of establishing "categorical centers devoted to a single disease" was questioned. Others saw a threat to the existing time-honored role of the practicing physician in patient care. It was explained that lack of clearly defined methodology in the bill was an effort to permit flexibility of approach to fulfill needs which might vary with the regions. Good and bad experiences were cited where strict adherence to pooling of patients for specialized disease-management has been at-

tempted in "categorized" private and military institutions. Departure from advantages offered by customary interdepartmental relationships is not an objective of the plan. Orientation of practice toward medical schools and hospitals was noted to be a definite trend, frequently with active support of physicians and the public, in urban communities. Medical schools, absorbed in research and training, are thought to be giving too little attention to the teaching and needs of the practitioner. It is believed that extension of continuing medical education and improvement of communications envisioned under the Regional Medical Programs will bring their "separate worlds closer together and permit each to learn from and assist the other."

The regional medical programs are intended to afford physicians and health institutions the opportunity to make available to their patients the latest advances in diagnosis and treatment of the designated diseases. To accomplish these purposes, the law proposes cooperative arrangements linking a region's health resources in programs of clinical research, education, training, and demonstrations of patient care. This is to be done without interfering with the patterns, or financing, of patient or professional care or with the administration of hospitals.

POLICY STATEMENTS

It was resolved:

1. That, for the benefit of Ohio physicians and their patients, methods of communication regarding Heart Disease, Cancer, and Stroke programs to physicians and their patients should be expanded. Consideration should be given to using and expanding the Ohio's medical television network to disseminate socioeconomic information to professional, paramedical and lay persons throughout Ohio.

2. That there should be maximum utilization of, liaison with and encouragement of

other presently existing organizations; medical, paramedical and lay; in Heart Disease, Cancer, and Stroke activities, under the direction of OSMA.

3. That the Ohio State Medical Association should promote and encourage additional programs expanding medical knowledge with regard to heart disease, cancer, and stroke among medical and paramedical personnel in physicians' offices, clinics, and hospitals in Ohio.

4. That the Ohio State Medical Association, its component county medical societies,

and individual physicians should be continually alert to the development of programs in the area of heart disease, cancer, and stroke and other government programs and should exert all influence to make certain that all programs are coordinated so that fragmentation is avoided. This alertness and activity will be to the benefit of all involved, patients and physicians.

5. That the Ohio State Medical Association and its component county medical societies and individual physicians should insist on periodic analysis of all programs in the heart disease, cancer, and stroke area, as well as other government medical care programs, so that "dead wood" in the programs is eliminated and so that procedures are revised to keep up with current problems.

Poverty Program

BACKGROUND INFORMATION

Preamble

The Economic Opportunity Act of 1964 contains seven titles, each of which deals with a particular aspect of the poverty problem or the administrative authority to carry out the Act. The Act establishes an office of Economic Opportunity in the Executive Office of the President with responsibility for coordinating the poverty-related programs of all Federal agencies.

The Office of Economic Opportunity (OEO) will operate a Job Corps, a program for Volunteers in Service to America (VISTA), a community action program, and special programs for migrant workers. In addition, the OEO will distribute funds to operate several programs authorized under the Act to existing agencies: the Department of Labor for work-training programs; the Department of Health, Education, and Welfare for work-study programs, adult basic education, and community work and training programs for welfare recipients; the Department of Agriculture for special rural anti-poverty programs; and the Small Business Administration for loans to small business.

Youth Programs (Title I)

A total of \$412.5 million is authorized for three youth programs:

- A Job Corps to provide education, work experience, and vocational training in conservation camps and residential training cen-

ters for some 40,000 young men and women, aged 16 to 21, this year, and 100,000 next year. Total first year cost is \$190 million.

- A work-training program under which agreements will be entered into with State and local governments or nonprofit organizations to pay part of the cost of full- or part-time employment to enable young men and women, 16 to 21, to continue or resume their education or to increase their employability. Some 200,000 young adults would be directly involved the first year at a total cost of \$150 million.

- A work-study program under which agreements will be entered into with institutions of higher learning to pay part of the cost of part-time employment for undergraduate or graduate students from low-income families to permit them to enter upon or continue college level education; 140,000 youths will be involved the first year at a total cost of \$72.5 million.

Community Action Programs (Title II)

The Community action section of the bill authorizes \$340 million for fiscal year 1965 to provide:

- Grants to pay up to 90 per cent of the total costs of financing antipoverty programs planned and carried out at the community level. Programs will be administered by the communities and will mobilize all available resources and facilities in a co-

ordinated attack on poverty. Total cost for the first year is \$315 million.

- Grants to States (\$25 million for fiscal year 1965) to provide basic education and literacy training to adults.
- The establishment of an information and coordination center to encourage voluntary assistance for deserving and needy children.

Programs to Combat Poverty in Rural Areas (Title III)

A total of \$35 million is authorized for:

- Loans up to \$2,500 to very low-income rural families where such loans are likely to produce a permanent increase in the income of such families, to finance nonagricultural, income-producing enterprises for the same purpose. The director of OEO also may make loans to low-income family cooperatives. The programs will be administered by the Department of Agriculture.
- A program of assistance to establish and operate housing, sanitation, education, and child-care programs for migrant farmworkers and their families.
- Indemnity payments to farmers for milk which had to be removed from the market because of pesticide contamination.

Employment and Investment Incentives (Title IV)

The OEO is authorized to make, participate in, or guarantee loans to a small business firm

of up to \$25,000 on more liberal terms than is possible under the regular loan provisions of the Small Business Act. This program, administered by the Small Business Administration, will use \$25 million of SBA's regular spending authority.

Work-Experience Programs (Title V)

Authorizes the Director of OEO to transfer funds (\$150 million the first year) to the Department of Health, Education, and Welfare to pay costs of experimental, pilot, or demonstration projects designed to stimulate the adoption by the States of programs providing constructive work experience or training for unemployed fathers and needy persons.

Administration and Coordination (Title VI)

Authorizes the Director of OEO to recruit and train VISTA volunteers to serve in specified mental health, migrant, Indian, and other federally-related programs including the Job Corps, as well as in State and community anti-poverty programs.

Treatment and Unemployment

Compensation and Income for Public Assistance Purposes (Title VII)

Establishes the policy that an individual's opportunity to participate in certain programs under this act would neither jeopardize, nor be jeopardized by, his receipt of unemployment compensation or public assistance.

POLICY STATEMENT

It was resolved:

1. That a medical report shall determine after discussion with the local welfare agencies, city health nurses, etc., the actual need for these programs. Should this need be determined in the affirmative, the following recommendations should be followed:

a. In any program financed by the Office of Economic Opportunity in an Ohio com-

munity there shall be representation at the highest policy level by an official representative of the appropriate county medical society involved.

b. Remuneration for services in above programs is to follow the policies of the Ohio State Medical Association with regard to all financial and contractual relationships.

Title XVIII Program (P. L. 89-97)

BACKGROUND INFORMATION

Members of the Ohio State Medical Association have been constantly exposed to explanatory information and background information with regard to the Medicare Program (P. L. 89-97). Therefore, we will not attempt to present in this report detailed background information with regard to this program. Members of the Association should re-read special

medicare Newsletters 1 through 7. These Newsletters have other information presented in the OSMAGram and previous issues of *The Ohio State Medical Journal* delineated a wealth of information and policy statements. However, the following additional policy statements with regard to Title 18 of the Medicare Program are presented for your information:

POLICY STATEMENTS

Policy statements are contained in the following resolutions adopted by The Council on recommendation of the Subcommittee on P. L. 89-97 Title 18, in which it was resolved:

1. That The Council of the Ohio State Medical Association seek introduction by Ohio Congressmen of legislation called for in the following resolution adopted by the House of Delegates of the American Medical Association at the 1966 Clinical Convention in Las Vegas (November 27 - December 1, 1966):

WHEREAS, the Social Security Act makes no specific provision for reimbursing eligible recipients of aid under Title XIX who have paid or wish to pay for their own medical services, and

WHEREAS, this effectively prevents the Title XIX recipients from obtaining care in the same fashion as other members of the community, and

WHEREAS, it actually deprives the Title XIX recipient who is covered under Part B of Title XVIII of the option of direct payment afforded other Title XVIII beneficiaries; therefore be it

RESOLVED, that the American Medical Association strongly support amendment of the Social Security Act including Title 18 to

permit payment without assignments for medical care of patients.

2. That The Council of the Ohio State Medical Association seek introduction by Ohio Congressmen of legislation called for in the following resolution adopted by the House of Delegates of the American Medical Association at the 1966 Clinical Convention in Las Vegas (November 17 - December 1, 1966):

RESOLVED, That the American Medical Association advise the Department of Health, Education, and Welfare that the present requirements for certification and recertification have proven highly objectionable, unnecessary, and do not contribute to the quality of medical care; and be it further

RESOLVED, That the American Medical Association endeavor to bring about repeal of those portions of P. L. 89-97 in which the requirement for physician certification of medical necessity appears; and be it further

RESOLVED, That the fiscal intermediaries and the American Hospital Association be advised that AMA will be available to assist in the development of appropriate amendments to this legislation. The purpose of this consultation would be to discuss the complexities of this requirement and to in-

vite participation in the development of amendments to the law which will be professionally acceptable and administratively workable.

3. That The Council reaffirm existing policy regarding utilization review committees, as follows:

(1) The function of a utilization review committee is a purely medical function.

(2) The responsibility and obligation of such committees are medical only.

(3) Every utilization review committee shall be composed solely of practicing physicians.

(4) When such a committee enters into an agreement or contract with any third party, the fulfillment of its medical responsibility and obligation is seriously jeopardized.

(5) When a utilization review committee or its individual members accept remuneration for carrying out the medical responsibilities of the committee, an employer-employee relationship is established, which leads to lay influence and control over matters which are strictly medical.

(6) Since the function of a utilization review committee is exclusively medical in nature and purpose, its findings and recom-

mendations should be limited to medical decisions and should not include recommendations with respect to third-party benefits to the patient.

(7) This Association recommends to each component County Medical Society that it point out to the utilization review committees in its county the proper function of such committees and the limits of their responsibilities and obligations.

(8) Each County Medical Society is urged to establish, or cause to be established, a utilization review committee. In event a County Medical Society does not have sufficient professional personnel available to establish an effective Utilization Review Committee, such County Society is urged to seek the aid of this Association in establishing an area Utilization Review Committee which would function in two or more counties.

4. That the OSMA file an official protest to "Criteria for Determination of Reasonable Charges; Reimbursement for Services of Hospital Interns, Residents, and Supervising Physicians" published in the February 8, 1967 issue of *The Federal Register*, and that copies of the protest be forwarded to all state medical associations, the AMA, and to all Ohio Congressmen.

Title XIX Program

BACKGROUND INFORMATION

The same statement made concerning background information of Title XVIII holds for

the Title XIX Program. Also, listed below are policy statements regarding this Program.

POLICY STATEMENT

It was resolved:

1. That guidelines to determine services that will be reimbursable under Title 19 be submitted to Dr. Theodore Light, the physician member of the Medical Advisory Committee to the Department of Public Welfare, with the request that he review the suggested Guidelines and make suggestions.

a. After this procedure has been followed, the suggested Guidelines be submitted to the Committee on Government Medical Care

Programs of the Ohio State Medical Association for study, review and recommendations.

2. That the Department of Welfare should enter into some form of dialogue with industry and industries which provide goods and services to welfare clients; and that in the future, efforts be made to consider all those who provide services to welfare recipients on the same level and that they be treated equally.

See Section II. June Issue of The Journal

Leaves of this color supplement are perforated
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Woman's Auxiliary Highlights...

By MRS. S. L. MELTZER, Chairman, Publicity Committee
2442 Dorman Drive, Portsmouth 45662

"BY THE SEA, By the sea, By the beautiful sea"—that's the place, that's the place, where it's going to be . . . I just can't help associating Atlantic City, New Jersey, with the words of that early twentieth-century song (I think I'm right about that!) Anyhow, lest I get carried away any further, let me be quick to point out that all this has to do with the forthcoming 44th annual convention of the Woman's Auxiliary to the American Medical Association to be held in fascinating Atlantic City, June 18 through June 22 at the Hotel Shelburne.

I can't think of a more tempting place in which to hold an important convention than this famous old New Jersey resort town. For those of you planning to bring your "young 'uns," the beautiful beach, the "breakers," the salt-tanged air are just a few of the attractions the junior set will love. A block of rooms has been set aside for auxiliary members at the Hotel Shelburne. Reservations must be made through the AMA Housing Bureau, 16 Central Pier, Atlantic City 08401.

On Sunday, June 18, a reception honoring the National President, Mrs. Asher Yaguda, and the President-Elect, Mrs. Karl Ritter (of OHIO!) will be held from 6:00 to 8:00 o'clock at the Shelburne Hotel. Also on that day will be the opening meeting of the AMA House of Delegates. The formal opening of the auxiliary convention will be at 9:00 A. M. on Monday, June 19. There will be a Guest Day luncheon for leaders of National Women's

Volunteer Organizations, Auxiliary members and guests at 12:30 P. M. that day in the ballroom at the Shelburne Hotel. Scheduled for Tuesday morning, June 20, is an appearance of Mary Calderone, M. D., noted authority on sex education. Also speaking on Tuesday will be Charles L. Hudson, M. D., Cleveland, AMA President, who will address the luncheon honoring past presidents and AMA officers and trustees. Again this year, the auxiliary will sponsor a teen-age program for children of physicians and guests attending the convention.

Getting back to Tuesday, June 20, there will be a Little Workshop from 2:30 to 3:30 P. M. which will be a two-way discussion between state presidents, presidents-elect and National officers and committee chairmen. Delegates are invited to attend. Questions and topics for discussion may be placed in the question box during convention. From 3:30 to 4:30 P. M., a Political Action program will be the feature. The Big Day for Ohio will be Wednesday, June 21, when our own Gerby Ritter (Lima) will be installed as president. That will be a proud and glorious moment for the Ohio State auxiliary members, just as it was relatively recently when Dena Evans (Youngstown) became National President.

Let's have a big and enthusiastic turn-out of Ohio members to show Gerby Ritter that we stand solidly behind her, that we are so very proud of her and that we wish for her a wonderful and successful year of stewardship.

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What I have listed here regarding National Convention is, of course, merely a bird's eye view, so to speak. There are many wonderful things planned, not only on the business end but on the social end. You couldn't find a better place in which to work and relax than at this queen of resort areas—by the sea, by the sea, by the beautiful sea . . . Come on in! The water's great!!

Around the State

Cuyahoga County has every reason to be proud of a recent and outstanding venture. It took the form of a forum that was presented by the auxiliary before some 500 educators and other community leaders. Mrs. Jay S. Ankeny was chairman of this special program called "Implementing Family Life Education In Our Schools." Working with her were Mrs. Rudolf Cooks and Mrs. Thomas Manning.

What has made this forum of unusual value is the follow-up that has been done. There has been a concentrated effort to put into effect some of the speakers' suggestions. Questions written by persons in the audience have had replies from speakers to whom the questions were addressed. Monthly meetings are now being held with panel members, Cuyahoga auxiliary members, and representatives of the Academy of Medicine to determine the most effective ways of implementing family life education in Cleveland area schools. This is a remarkable step forward—making a real attempt to put into practice what has been discussed.

Among those taking part in the forum were: Alan C. Shankland, executive secretary of the Cuyahoga County School Superintendents Association; Joseph P. Martin, M. D., member of the Public Health Advisory Board of Cleveland; Stanley D. Wagy, director of the Health Family Association; Rev. F. Washington Jarvis, St. Paul's Episcopal Church; William W. Herman, M. D., chairman of the Family Life Education Committee of the Academy of Medi-

cine; and John J. Beeston, M. D., director of the Cleveland Health Museum. Mrs. Rudolf O. Cooks, auxiliary president, has outlined these approaches to be tried:

Setting up programs with universities so that teachers can obtain credit hours, possibly toward a master's degree; special training classes for teachers in the community in the fall; six weeks of classes in the community during the summer. Texts of the talks given by the principal speakers have been distributed to various interested schools and agencies.

That Apple Tree

Hamilton County women have been at it again—working to raise funds for the Apple Tree and other philanthropies. We've had quite a bit to say about the Apple Tree in past months, but for those of you who might have missed the stories, the Apple Tree is a day-care nursery supported by the auxiliary to care for children of professional hospital personnel—so that more womanpower is available to area hospitals. There was a "dress-up" occasion recently as the Hamilton group held its annual spring benefit fashion show at the Statler-Hilton Hofbrau Haus Restaurant. Mrs. Don Aichholz was general chairman of the event which featured fashions from Henry Harris. Mrs. Rhoda Barrett, daughter of Harold Stahl, founder of Highlight, did the commentary. She came from New York where she works with store buyers, merchandise managers, fashion coordinators and display designers.

Auxiliary members who modeled the Pat Sandler designs included: Mrs. Joseph H. Goldcamp, Mrs. Lowell E. Golter, Jr., Mrs. Curwood R. Hunter, Mrs. F. L. Mendez, Jr., Mrs. Thomas J. Mussio, Mrs. Joseph N. Wilson, Mrs. Jerome F. Wiot, and Mrs. Albert Zoss. Assisting with arrangements for the fashion show were Mrs. Robert L. Coith, vice-chairman; Mrs. Robert S. Heidt, advisory chairman; Mrs. H. Hudson Baumes, decorations; Mrs. Frank

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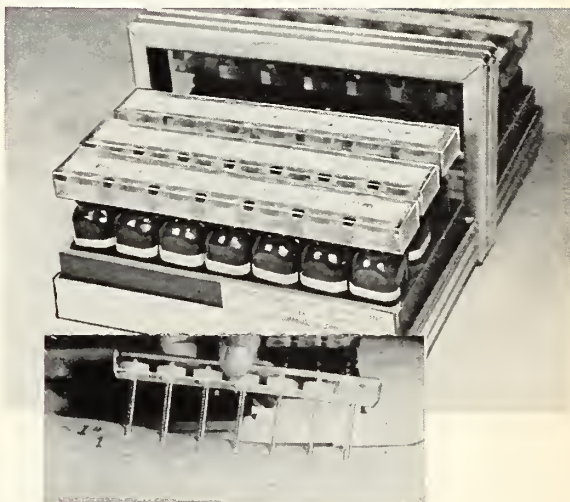
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W. Canciolo, invitations; Mrs. Richard S. Kerstine, hospitality; Mrs. Noble O. Fowler, treasurer; Mrs. Ben Yamaguchi, prizes; and Mrs. Dale E. Fox, reservations.

The Licking County group met recently in the home of Mrs. W. A. Avery, with Mrs. R. G. Plummer as cohostess. Dinner was followed by a program presented by the Welsh Hills Players under the direction of Norma McCune. A reading, "Here We Are" was given by Dorothy Parker. Following the program, a business meeting was conducted by Mrs. R. F. Sylvester, president.

The Lima and Allen County auxiliary members were captivated, at the group's March meeting, by the 90-minute illustrated talk given by Lima neurosurgeon, Dr. Bernard Glass, who described his eight weeks' service with S. S. Hope. Speaking at the Lost Creek Country Club, Dr. Glass vividly described Project Hope, the people, their way of life, and medical needs, as he found them in Nicaragua last summer. His reward, he said, was the satisfaction of helping those who needed that help. He explained that half of the population dies before the age of six due to malaria and other diseases, even gunshot wounds. "People who live to be 50 are thought old," he said. While the ship was in the capital, Dr. Glass visited in the area in order to study the country's economy and living conditions.

Mrs. Thomas J. Roess, president, conducted the meeting which followed a luncheon. The hostess committee included: Mrs. Robert G. Hendershot, chairman; Mrs. J. R. Romaker, Mrs. Walter Yingling, Mrs. Clyde Conger, Mrs. R. E. Bushong, Mrs. Robert Zarzar, Mrs. Robert Curry, Mrs. John Hubbell, and Mrs. Ernest Schoeniger.

Vietnam Report

Dr. William B. Gallagher, surgeon at the Skemp Clinic in La Cross, Wisconsin, gave Lucas County members and guests a "second-hand" trip to Vietnam at its March 14 meeting. Dr. Gallagher has recently returned from a 60-day tour of duty in Bac Lieu as a volunteer with the AMA's project Vietnam. Bac Lieu is in the southern part of the country, in the Mekong Delta region.

The doctor accompanied his talk with colored slides, starting with maps of the area so that the women would know where they were "going." The pictorial tour took them on the airplane, over the countryside and to the provincial hospital caring for the civilian Vietnamese population. They were made aware of the work done by Dr. Gallagher and other AMA volunteers, sympathized with the frustrations over inadequate supplies and equipment, felt the horror of the war as well as the ravages of disease in a medically understaffed country, and were brought

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Warning: Not of value in the treatment of psychotic patients, and should not be employed in lieu of appropriate treatment.

Precautions: Limit dosage to smallest effective amount in elderly or debilitated patients (not more than 1 mg, one or two times daily initially) to preclude ataxia or oversedation, increasing gradually as needed or tolerated. As is true of all CNS-acting drugs, until correct maintenance dosage is established, advise patients against possibly hazardous procedures requiring complete mental alertness or physical coordination. Driving during therapy not recommended. In general, concurrent use with other psychotropic agents is not recommended. If such combination therapy is used, carefully consider individual pharmacologic effects—particularly with known compounds which may potentiate action of Valium (diazepam), such as phenothiazines, barbiturates, MAO inhibitors and other antidepressants. Advise patients against simultaneous ingestion of alcohol or other CNS depressants. Safe use in pregnancy not established. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Observe usual precautions in impaired renal or hepatic function. Periodic blood counts and liver function tests advisable in long-term use. Cease therapy gradually.

Side Effects: Side effects (usually dose-related) are fatigue, drowsiness and ataxia. Also reported: mild nausea, dizziness, blurred vision, diplopia, headache, incontinence, slurred speech, tremor and skin rash; paradoxical reactions (excitement, depression, stimulation, sleep disturbances, acute hyperexcited states, hallucinations); changes in EEG patterns during and after drug treatment. Abrupt cessation after prolonged overdosage may produce withdrawal symptoms (convulsions, tremor, abdominal and muscle cramps, vomiting, sweating) similar to those seen with barbiturates, meprobamate and chlordiazepoxide HCl.

Dosage—Adults: Mild to moderate psychoneurotic reactions, 2 to 5 mg b.i.d. or t.i.d.; severe psychoneurotic reactions, 5 to 10 mg t.i.d. or q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; muscle spasm with cerebral palsy or athetosis, 2 to 10 mg t.i.d. or q.i.d. *Geriatric patients:* 1 or 2 mg/day initially, increase gradually as needed and tolerated. (See Precautions)

Supplied: Valium[®] (diazepam) Tablets, 2 mg, 5 mg and 10 mg; bottles of 50 and 500.



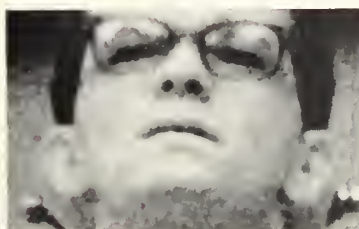
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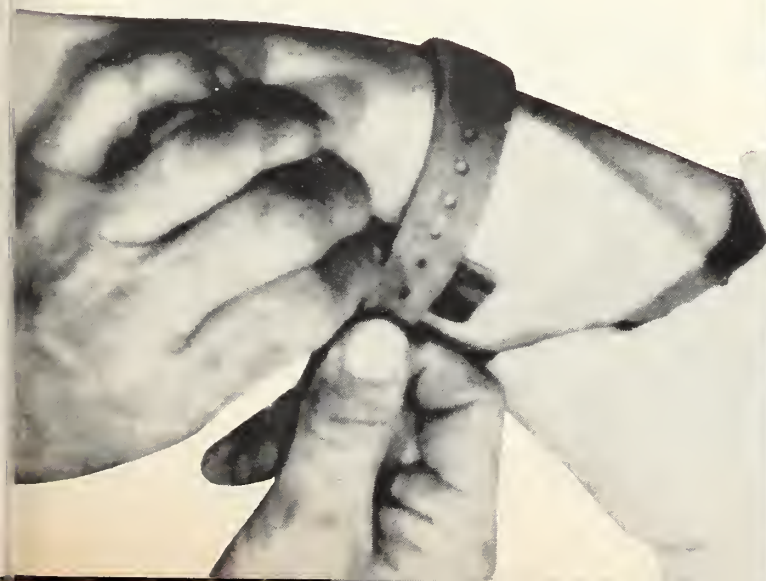
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Please see opposite page for important prescribing information.



to the realization of the gentle stoicism of the Vietnamese people.

Mrs. A. J. Kuehn, city chairman of the Citizens' Day Care Centers, deserves a printed orchid for the fine job she has been doing. She in turn says "hats off and our warmest thanks to Mrs. John Jones, Mrs. Robert Smith, Mrs. Robert Cooke, Mrs. James Fries, and Mrs. Charles Bohnegel for their over 400 volunteer hours with the children in our three Day Care Centers during this past six months period."

Trumbull County auxiliary recently presented a check to Dr. George L. Lielbriedis, director of the Trumbull County Guidance Center, for his organization's work with children of average to superior intelligence who, because of some psychiatric problem, are behind in their school work.

The auxiliary's March meeting was held at the home of Mrs. John Phillips, president-elect. April was a big month for these Trumbull women. On three consecutive Saturdays, they sponsored their Health Career Day programs at the various high schools. All those who attended met first for workshop in various areas of health. Each participant had the chance to take part in several different classes. The group relaxed for a "sack lunch" following which workshops were again conducted. Students were given an opportunity to sign for tours in the area's hospital of his or her choice.

Mrs. Robert Hastedt was elected president of the Tuscarawas auxiliary at the group's March meeting at the home of Mrs. H. F. VanEpps. Those who will serve with her include: Mrs. Lee Appel, president-elect; Mrs. Efrain Padro, secretary, and Mrs. R. J. Foster, treasurer. The February meeting of the group was for the benefit of its Health Careers Loan Fund. Instead of the annual dinner meeting, there was a "glorified" cocktail party and buffet. Again, Dr. and Mrs. William Hudson opened their home to the auxiliary for this annual benefit. Dur-

ing the evening, music was furnished by Mr. Ray Besozzi who donated his time and talent. The committee assisting Mrs. Hudson included: Mrs. Hastedt; Mrs. Paul Ebert; Mrs. Robert Kuba; Mrs. James Hamilton; and Mrs. Gene Hammersley.

Remember May!

The 16th through the 19th, to be exact. Convention time — get-together time — wonderful time! Be seeing you. . . .

Ohio State Medical Golfers To Play at Marion Club

The Ohio State Medical Golfers' Association has issued an invitation for all Ohio physicians who are interested to come out for the 42nd Annual Ohio State Medical Tournament on Thursday, June 8. Place is the Marion Country Club, on State Route 4, four miles southwest of Marion.

OSMGA golfers are welcome for practice rounds on Wednesday afternoon after 1:45 P. M., and are invited to attend the monthly stag dinner at the club on Wednesday evening, June 7. Reservations for the stag dinner should be sent to J. S. Greetham, M. D., Marion Committee Chairman, 313 Bradford Street, Marion, Ohio 43302 by June 5.

Thursday tee off time is 8:00 A. M. to 2:00 P. M. Luncheon is from 11:30 A. M. to 1:30 P. M. The traditional banquet and awards meeting will begin at 6:30 P. M.

A fee of \$25.00 includes green fees, luncheon, banquet, prizes, and use of locker room. Reservations should be sent to Bob Elwell, Secretary (at the headquarters of the Academy of Medicine of Toledo), 3101 Collingwood Blvd., Toledo, Ohio 43610. Golfers who have a handicap certificate should present it at the registration desk.



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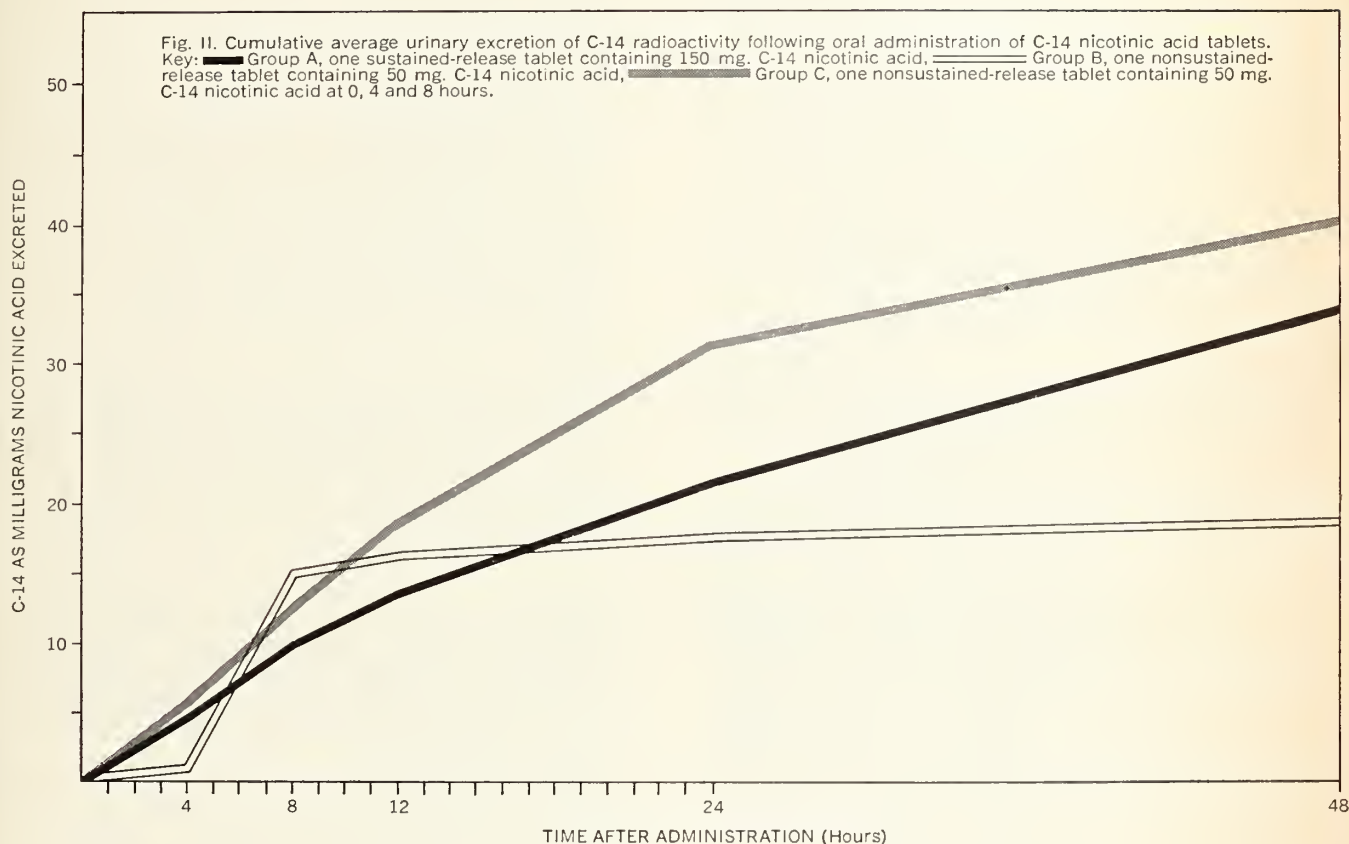
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Contraindications: There are no known contraindications.

Precautions: Exercise caution when treating patients with a low convulsive threshold.

Side Effects: Side effects are rarely encountered, however due to the vasodilatation effect of nicotinic acid, transitory mild nausea, flushing, tingling and pruritus are possible.

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References: 1. Report by Nuclear Science & Engineering Corp., Pittsburgh, Pa., in files of Philips Roxane Laboratories. 2. Connolly, R.: W. Virginia Med. J. 56:263 (Aug.) 1960. 3. Curran, T. R., and Phelps, D. K.: Am. Pract. & Digest Treat. 11:617 (July) 1960.



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HURON—Richard L. Jackson, President, 15 East Emerald Street, Willard 44890; John Rosso, Secretary, 218 Myrtle Avenue, Willard 44890; 2nd Wednesday of February, April, June, August, October, and December.

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Dr. Charles E. Jaeckle was cochairman of a program at the Defiance Rotary Club, where he showed a film, "Not As It Was," a presentation by the American Medical Association depicting the practice of medicine today.

Dr. John E. Stephens, physician for the Columbus Jets baseball club, spoke at a luncheon meeting of the Columbus Downtown Optimist Club, where he described his experiences during a recent "Physicians for Vietnam" tour.



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The Journal does not assume responsibility for opinions expressed by the essayists. Advertisers must conform to policies and regulations established by The Council of the Ohio State Medical Association.

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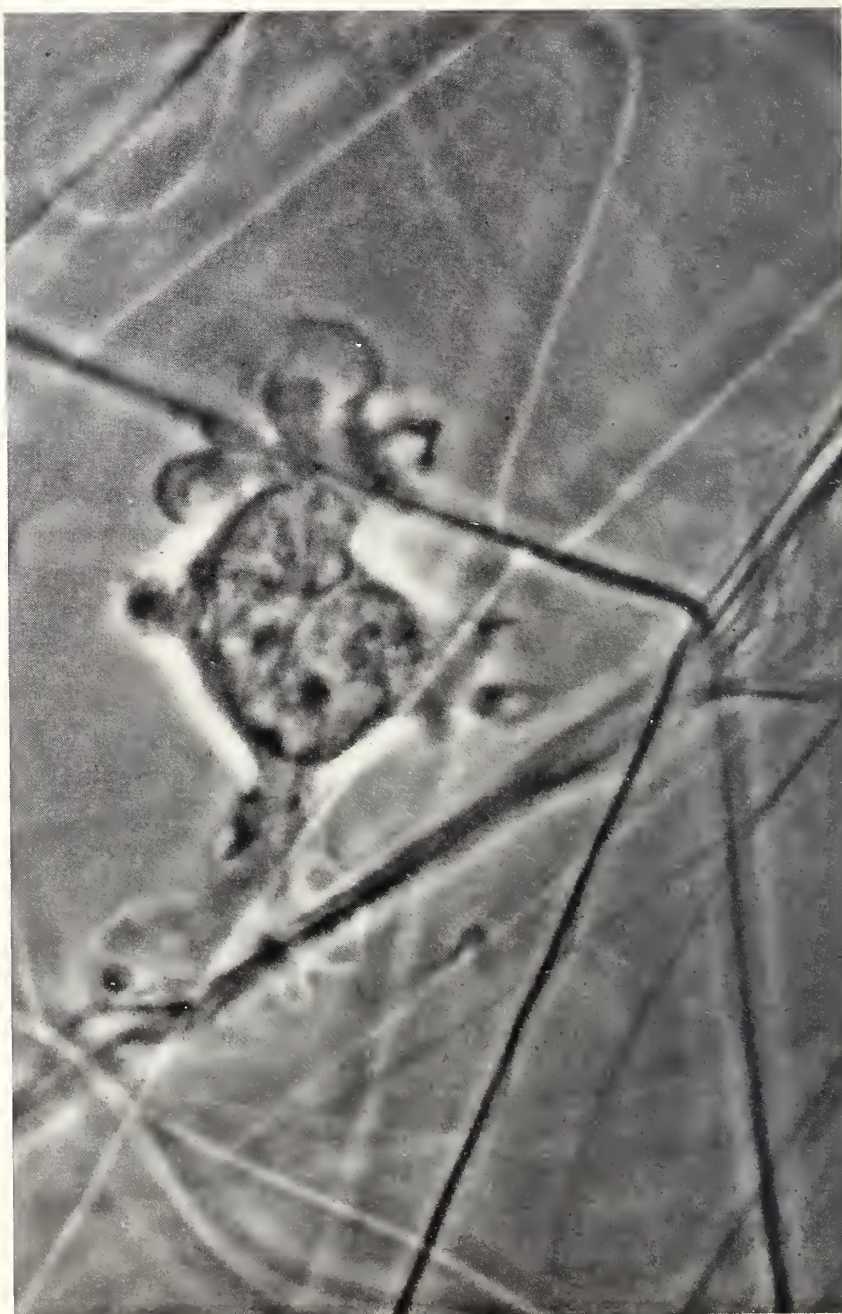
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INFLAMMATION: A cellular fight for life

A SYNTEX REPORT based on recently developed hypotheses about topical corticosteroids, including the cellular theories of inflammation by Thomas F. Dougherty, Ph.D., University of Utah.

You are looking at a fibroblast fighting for life. This cell—one of the most common found in connective tissue—has literally been poisoned by cytotoxins released from other cells that have ruptured. Soon, if the abnormal activity of this fibroblast does not cease, it, too, will rupture and die—one more casualty in the inflammatory wave of destruction precipitated by injury.

Until a short time ago no one had ever witnessed such a scene at the cellular level. Now, through advanced cinemicrographic techniques, it is possible to view and photograph the inflammatory process as produced experimentally in living animal tissue. This method permits new insight into the mechanism of inflammation and the role of corticosteroids in therapeutic management. Equally important, these techniques shed new light on factors that may make one corticosteroid more effective than another—factors that can be correlated with other chemical, biologic, and clinical parameters.



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Seborrheic Dermatitis	18	442	426
Atopic Dermatitis	24	460	426
Psoriasis	36	1,699	1,510
Neurodermatitis	18	351	324
Total	144	4,174	3,808

*Complete bibliography on request.

†Expressed by the authors as excellent, very good, good, complete remission of inflammation, etc.

longed periods of time. Prolonged use of any antibiotic may result in overgrowth of nonsusceptible organisms; if this occurs, appropriate therapy should be instituted. When severe local infection or systemic infection exists, the use of systemic antibiotics should be considered, based on susceptibility testing. **SIDE EFFECTS:** Side effects are not ordinarily encountered with topically applied corticosteroids. As with all drugs, however, a few patients may react unfavorably to Synalar under certain conditions. The neomycin in Neo-Synalar Cream rarely produces allergic reactions.

REFERENCES: 1. Lerner, L. J., Bianchi, A., Turkheimer, A. R., Singer, F. M., and Borman, A.: Anti-inflammatory steroids: potency, duration and modification of activities. *Ann NY Acad Sci* 116:1071 (Aug. 27) 1964. 2. Idem: Comparison of anti-granuloma, thymolytic and glucocorticoid activities of anti-inflammatory steroids. *Proc Soc Exp Biol Med* 116:385 (June) 1964. 3. Ringler, A.: Activities of adrenocorticosteroids in experimental animals and man, in Dorfman, R. I.: *Methods of hormone research*, New York, Academic Press, 1964. vol. III. pp. 234-280. 4. Gubersky, V. R.: To be published.

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Western Reserve Construction Progressing in Cleveland

Construction of Western Reserve University's Health Science Center is now underway at the five-acre building site in southeast University Circle.

Dr. John S. Millis, president of WRU, turned the first shovel of earth early in the spring for the massive Center which will take 30 to 36 months to complete at a cost exceeding \$30-million.

The Center will provide new facilities for WRU's Schools of Dentistry and Nursing and an East Wing addition and administration tower for the School of Medicine. It will permit an enrollment increase in the health sciences from the present 800 undergraduates to more than 1,200 and enable WRU to expand its graduate program in the health fields.

The main construction work until midsummer will be scooping out the mammoth five-acre foundation. Following that, footings will be laid and concrete poured to form the extensive series of columns required to shore up the "podium" — the broad, story-high platform upon which the superstructures of the three schools will rise.

Simultaneously, basic work is under way on the nursing and dental school buildings which have a target completion date of 24 months. The medical

school wing and administration tower are expected to be completed within 30 to 36 months.

The project will be two-thirds community financed, with the remaining third guaranteed in federal grants. According to Ben De John, WRU director of construction, government officials involved in approving the federal share of \$13-million have indicated that the Center is the largest university health science project under construction in the country.

The construction program for the complex, the third project of the University Medical Center Development Program, culminates nearly six years of planning.

Established Award in Ecology Honors Columbus Physician

The Board of Directors of the American Society for the Study of Clinical Ecology meeting in New Orleans on March 19-23, in connection with the American College of Allergists, voted to establish the Jonathan Forman Annual Award for the best paper produced in this field by the membership.

Dr. Forman, Columbus physician specializing in the field of allergy, is active in numerous professional organizations, both in his specialty field and in related fields of medicine.

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Medicine and Religion Movement Growth Is Phenomenal; 48 States, 622 Counties Have Organized Groups

THE swift growth and universal acceptance of the American Medical Association's Medicine and Religion Program has proved it is fulfilling the national need to establish a dialogue between the physician and clergy, says Milford O. Rouse, M. D., AMA President-Elect.

He urged individual physicians to invite the clergyman to become a part of the health team. Dr. Rouse made the appeal at the National Meeting of State Medical Society Medicine and Religion Committee Chairmen recently held in Chicago.

"This has been one of the most universally well received programs ever launched by the AMA," Dr. Rouse said. "It is one of the only programs, in my experience, which has never been criticized."

Founded in 1961: The AMA's Department of Medicine and Religion was established in September, 1961. Its goal is to bring the clergyman and physician together to provide total care and treatment of the patient, recognizing that man is spiritual, emotional and social as well as physical.

Recognizing the importance of this "whole being" concept, the AMA Board of Trustees established a Committee on Medicine and Religion consisting of a chairman, 10 physicians and 10 clergymen.

In the latter part of 1962, after extensive exploratory and planning work, eight state medicine and religion pilot programs were established.

Committee's Increase: Today there are 48 state

Editor's Note: A personal communication from the Rev. Paul B. McCleave, D. D., director of the AMA Department of Medicine and Religion, requests that *The Journal* call attention of Ohio physicians to an article which appeared in the March 6 issue of the *AMA News*. For the benefit of physicians who did not see the article, it is reproduced here in its entirety.

and 622 county society Medicine and Religion Committees throughout the nation.

At the national meeting of committee chairmen it became clear that the program is taking on a new emphasis, shifting from the organizational to the operational phase.

This change is reflected in the program to be presented by the AMA Committee on Medicine and Religion at the AMA's Annual Convention June 18-22 in Atlantic City.

Instead of dealing with the concepts of the medicine and religion program, as has been done the past two years, this year's program will deal with specific problems, such as the unwed mother, contraceptives and the coed, abortion, and alcoholism.

State Activities: The change also was apparent from reports about state committee activities.

Rev. Richard K. Young, D. D., chairman of the Subcommittee for Theological Seminary Education,

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said there is a real interest and need to move the program to the seminary level.

Training for MDs: William P. Williamson, M. D., speaking on postgraduate education, said there also is a "genuine need" for this type program at the postgraduate level of medical education.

Due to the successful experiences with formal postgraduate seminars on medicine and religion, he suggested that such programs be more widely instituted.

Major Challenge: It was clear that the rapid growth and universal interest in the medicine and religion program is providing a major challenge to the established committees to provide continuity and planning.

"The program has mushroomed so fast we only have a limited knowledge of what has been accomplished," George W. Petznick, M. D., Cleveland, chairman of Subcommittee on State and County Programs, said.

Of "utmost importance" in maintaining the momentum of this "dynamic program," he said, is providing continuity and guidance in planning meetings at the state and local levels.

Continuity: Winslow G. Fox, M. D., chairman of the Michigan State Medical Society Committee on Medicine and Religion, agreed.

Because of the swift growth of the programs at the state level, the state committees "must concentrate on proving continuity." He said the determination must be made as to what has been accomplished and what remains to be done in establishing a dialogue between the physician and clergy.

R. Paul Ferguson, M. D., chairman of the Iowa Medical Society committee, said the medicine and religion program at the national and state levels is now "tooled up and a going concern."

Success now depends on bringing physicians and the clergy together at the patient's bedside, he said.

The program already has demonstrated that both the clergyman and physician recognize the need for this interaction, but he suggested that the physician must provide the initiative to bring the two professions together.

Addendum: Ohio can be proud that it was one of the first states to organize a Committee on Medicine and Religion. Dr. Charles A. Sebastian, Cincinnati, chairman of Ohio's committee, represented this State at the meeting referred to in this article.

The University of Wisconsin Medical Center will present a course, entitled "Basic and Clinical Aspects of Therapy in Advanced Cancer," October 16-21. Persons interested are invited to contact R. J. Samp, M. D., Cancer Program Coordinator, University Hospitals, Madison, Wisconsin 53706.

WHAT TO WRITE FOR

The Look You Like — A 130-page publication for the general public giving answers to questions about skin care and cosmetics for all ages. Sold at cost by the American Medical Association, 535 N. Dearborn St., Chicago, Illinois 60610; \$1.20 per copy in the U. S. and Possessions, Canada, and Mexico.

Let's Talk About Food — Edited by the American Medical Association Council on Foods and Nutrition, this publication helps the general public to separate fact from fallacy with regard to proper nutrition. A compilation of 250 selected questions and answers on this subject from *Today's Health*. Order from the AMA, 535 N. Dearborn St., Chicago, Illinois 60610; \$1.20 in the U. S. Possessions and Canada, and Mexico.

Three Views of Hypertension and Heart Disease — This is one in a series of studies by the U. S. Public Health Service, described as "examination diagnosis of hypertension and heart disease made in the first cycle of the Health Examination Survey are compared with reports of these diseases on a self-administered medical history and on an inquiry completed by the person's own physician. Public Health Service Publication No. 1000—Series 2—No. 22; for sale by the Superintendent of Documents, U. S. Government Printing Office, Washington, D. C. 20402—price 35 cents.

Alcoholism in Industry — A 24-page booklet available at \$1.00 per copy from the Industrial Medical Association, 55 East Washington Street, Chicago, Illinois 60602.

Adoption of Children. A publication of the American Academy of Pediatrics providing a comprehensive study dealing with all facets of the adoptive process; in-depth information for physicians, attorneys, social workers, and others. American Academy of Pediatrics, 1801 Hinman Ave., Evanston, Illinois 60204; \$1.50 per copy.

Disciplinary Digest Booklet Issued by AMA Law Staff

"Disciplinary Digest" is the title of a booklet prepared this year by the Law Division staff of the American Medical Association. This digest is a collection of court decisions relating to disciplinary actions by state boards of medical examiners.

It is so arranged and indexed that it comprises a monograph on administrative procedures. A subject index is supplemented by a list of cases and a table of cases by jurisdiction.

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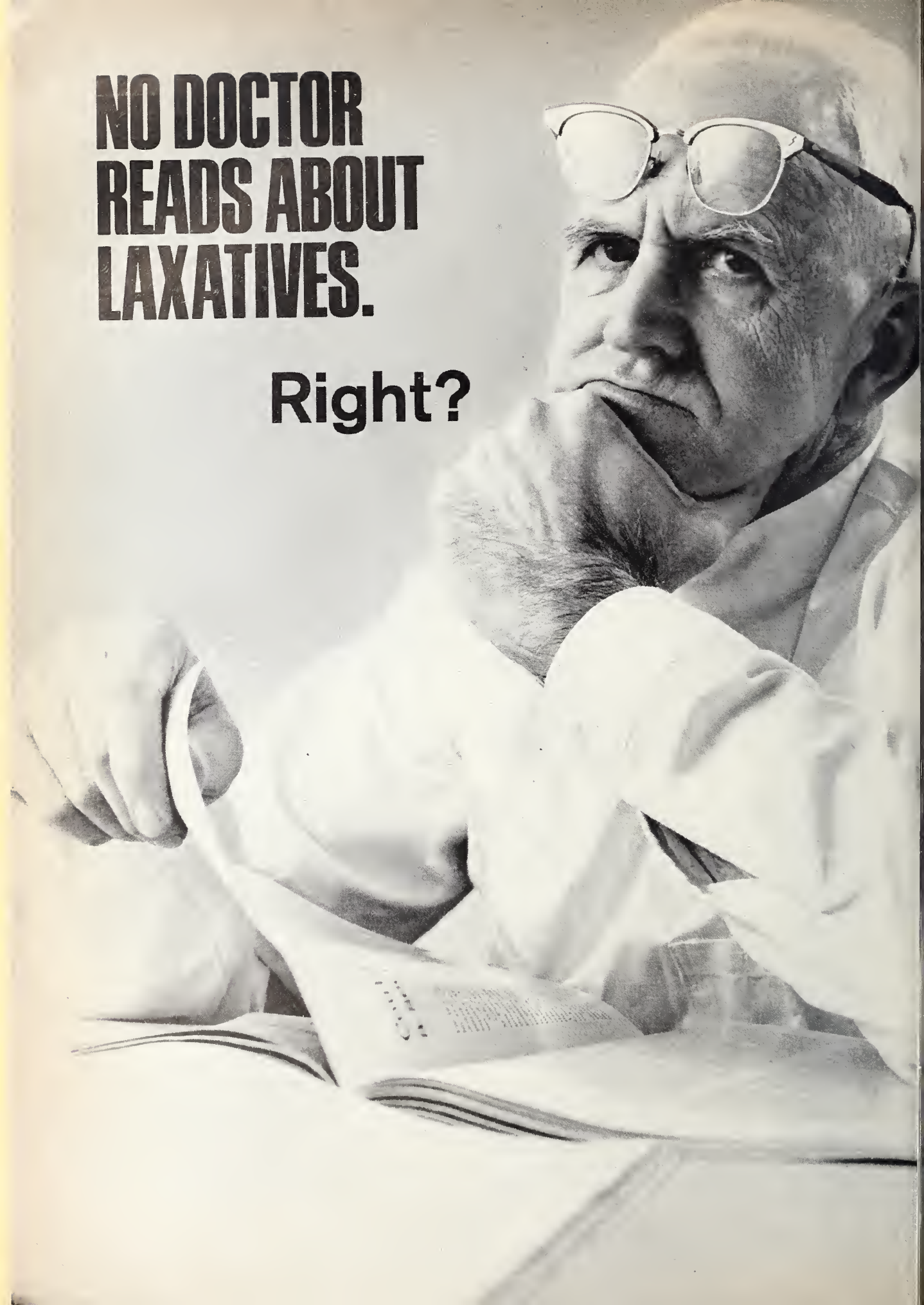
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One measure, of course, is reassurance. Another, adjunctive measure, is EQUANIL (meprobamate).

Over a decade of experience has shown that EQUANIL (meprobamate) is generally well tolerated as well as effective. Side effects are usually limited to transient drowsiness; serious, therapy-interrupting side effects are rare.

Cautions: Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use may result in dependence or habituation in susceptible persons—as ex-addicts, alcoholics, severe psychoneurotics. After prolonged high dosage, drug should be withdrawn gradually to avoid possibly severe withdrawal reactions including epileptiform seizures. Side effects include drowsiness and, rarely, allergic or idiosyncratic reactions. These reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Mild reactions are characterized by urticarial or erythematous maculopapular rash. Acute non-thrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever have been reported. Meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Warn patients of possible reduced alcohol tolerance. Should drowsiness, ataxia, or visual disturbances occur, dose

should be reduced. If symptoms persist, patients should not operate vehicles or dangerous machinery. A few cases of leukopenia, usually transient, have been reported following prolonged dosage. Other blood dyscrasias—aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia—have occurred rarely, almost always in the presence of known toxic agents. One fatal case of bullous dermatitis following intermittent use of meprobamate with prednisolone has been reported. Prescribe very cautiously for patients with suicidal tendencies. Suicidal attempts should be treated with immediate gastric lavage and appropriate supportive therapy.

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Comments on Current Economic, Social And Professional Matters

NOTED: PHYSICIANS' CONTRIBUTIONS TO THE LITERARY WORLD

To recognize the doctors' interest and achievements in the world of literature, *The Journal of the American Medical Association* has founded a tradition by dedicating an issue each year to the relations of medicine and letters. *JAMA's* fourth annual Book Issue was published April 3.

Among its 15 articles, this year's issue features a study of Civil War books by physicians, a review of Sigmund Freud's hundreds of letters to friends, best-selling author-physician Frank G. Slaughter's account of his decision to be a writer instead of surgeon, and a survey of a kind of book that was unusually popular in early day America, the do-it-yourself home medical adviser. There also are scholarly articles on books, plays, and libraries, and some lighthearted satire and parodies of medical life.

Editor of the Book Issue is Lester King, M. D., a senior editor of *JAMA*.

In our opinion, the Book Issue of *JAMA*, is a fitting tribute to the physician-scholar as well as a source of rich information for the publication's readers.

NEWSPAPER EDITORIAL DEPLORES CANCER "CURE" ANNOUNCEMENTS

In our opinion, the *Columbus Citizen-Journal* deserves a word of commendation for a recent editorial entitled "Another Cancer Cure Fails." Such comments as are expressed in this article do much to give the public a true perspective of progress that is being made in the cancer field.

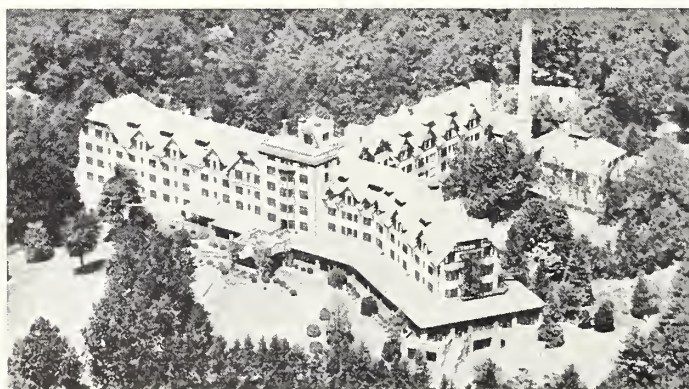
The editorial reads as follows:

Early this month, a clinic in Dallas, Tex., reported

(Continued on Page 763)

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(In Our Opinion—Contd. from P. 758)

the discovery of a drug that might cure leukemia—a cancer of the blood that is practically 100 per cent fatal.

The claim was based on the fact that a nine-year-old leukemia patient who took the drug for 31 days showed no signs of the dreaded disease for two whole weeks afterward!

All over the world parents of children with leukemia took heart. And many of them began calling the Dallas clinic to find how their dying youngsters also could get this cure.

Overshadowed by all the excitement was the sober observation of Dr. C. Gordon Zubrod, one of the top researchers at the federal government's National Cancer Institute:

"One (leukemia) patient going into complete remission for two weeks isn't very impressive. Only time will tell, and it takes years to find this out."

Not even Dr. Zubrod could have guessed that in less than a month the highly publicized leukemia cure would wear off. The boy who only a few days ago was regarded as cured, has been found to be suffering again from the dreaded cancer.

This is doubly tragic. It is a tragedy that leukemia remains incurable. And it is a tragedy that so

many people were misled into believing a cure was at hand.

Researchers wrestling with a problem as terrible as this must learn to curb their enthusiasms and to refrain from making premature claims of cancer cures. Fanning false hope is no way to build confidence in medical science.—*Columbus Citizen-Journal*, April 25, 1967.

Allied Medical Services School Directors Meet in Columbus

Ohio State University's School of Allied Medical Services recently hosted a meeting of directors and deans of 12 other schools or colleges of this type in an exploration of program, faculty, funds, and ideas.

Dr. Robert J. Atwell, director of the Ohio State school, said that all 13 schools have originated within the past three or four years.

Those attending represent Temple University, Indiana University, University of Kentucky, University of Pennsylvania, Boston University, University of Florida, Northeastern University, State University of New York at Buffalo, University of Illinois, St. Louis University, Medical College of South Carolina, and Loma Linda University, Calif.

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*"Sexual impotence treatment with methyl testosterone — thyroid (ANDROID) a double blind study" — Montesano, Evangelista: *Clinical Medicine*, April 1966.

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Dose: 1 tablet 3 times daily.
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Each orange tablet contains:
Methyl Testosterone . . . 12.5 mg.
Thyroid Ext. (1 gr.) . . . 64 mg.
Glutamic Acid . . . 50 mg.
Thiamine HCL . . . 10 mg.
Dose: 1 or 2 tablets daily.
Available:
Bottles of 60, 500.

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Each white tablet contains:
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Ascorbic Acid (Vit. C) . . . 250 mg.
Thiamine HCL . . . 25 mg.
Glutamic Acid . . . 100 mg.
Pyridoxine HCL . . . 5 mg.
Niacinamide . . . 75 mg.
Calcium Pantothenate . . . 10 mg.
Vitamin B-12 . . . 2.5 mcg.
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Glutamic Acid . . . 50 mg.

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'Thorazine' is useful as a specific adjuvant in the above named conditions.

The following is a brief precautionary statement. Before prescribing, the physician should be familiar with the complete prescribing information in SK&F literature or *PDR*. **Contraindications:** Comatose states or the presence of large amounts of C.N.S. depressants. **Precautions:** Potentiation of C.N.S. depressants may occur (reduce dosage of C.N.S. depressants when used concomitantly). Antiemetic effect may mask other conditions. Possibility of drowsiness should be borne in mind for patients who drive cars, etc. In pregnancy, use only when necessary to the welfare of the patient. **Side Effects:** Occasionally transitory drowsiness; dry mouth; nasal congestion; constipation; amenorrhea; mild fever; hypotensive effects, sometimes severe with

I.M. administration; epinephrine effects may be reversed; dermatological reactions; parkinsonism-like symptoms on high dosage (in rare instances, may persist); weight gain; miosis; lactation and moderate breast engorgement (in females on high dosages); and less frequently cholestatic jaundice. Side effects occurring rarely include: mydriasis; agranulocytosis; skin pigmentation, lenticular and corneal deposits (after prolonged substantial dosages).

For a comprehensive presentation of 'Thorazine' prescribing information and side effects reported with phenothiazine derivatives, please refer to SK&F literature or *PDR*.

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Mild mood depression, poor appetite, little interest in the present or future. Does this picture mean that she's giving in to functional fatigue?

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And for your patient's sake, prescribe Alertonic in the convenient, economical one-pint bottle.

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Each 45 cc. (3 tablespoonfuls) contains: alcohol, 15%; pipradrol hydrochloride, 2 mg.; thiamine hydrochloride (vitamin B₁) (10 MDR*), 10 mg.; riboflavin (vitamin B₂) (4 MDR), 5 mg.; pyridoxine hydrochloride (vitamin B₆), 1 mg.; niacinamide (5 MDR), 50 mg.; choline,† 100 mg.; inositol,† 100 mg.; calcium glycerophosphate, 100 mg. (supplies 2% MDR for calcium and for phosphorus) and 1 mg. each of the following: cobalt (as chloride), manganese (as sulfate), magnesium (as acetate), zinc (as acetate), and molybdenum (as ammonium molybdate).

*Multiple of adult Minimum Daily Requirement supplied.

†The need for these substances in human nutrition has not been established.

Indications: 1. Functional fatigue such as that often associated with: a depressing experience or stressful time of life; advancing years; convalescence; limited activity or confinement. 2. Poor appetite and vitamin-mineral deficiency as they occur in: patients having faulty eating habits; geriatric patients who are losing interest in food; patients convalescing from debilitating illness or surgery.

Contraindications: As with other drugs with CNS stimulating action, Alertonic is contraindicated in hyperactive, agitated or severely anxious patients and in chorea or obsessive compulsive states.

Side effects: Reports of overstimulation have been rare. Patients who are known to be unduly sensitive to the effects of stimulant drugs should be observed carefully in the initial stages of treatment.

Dosage: Adults, 1 tablespoonful; children (over 15 years old), 1 to 2 teaspoonfuls; children (4 to 15 years old), 1 teaspoonful. To be taken three times daily 30 minutes before meals.

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Cincinnati Radiological Heritage

The First Fifteen Years

STANLEY LUCAS, M.D.*

PART I

IN TODAY'S world of fast-moving changes and discoveries, it is easy to lose perspective of our heritage and the direction of our progress. This is true in the field of radiology, a relatively new branch of medical science but certainly now of mature age. A knowledge of radiological history helps the evaluation of isolated information regarding special procedures, new film exposure techniques, reports of unusual and new diseases, interpretation of therapeutic results and equipment advances. It is for this reason that the first 15 years of Radiology in Cincinnati, Ohio is now being reviewed. The names of the individuals involved are perhaps significant primarily to the region but the subjects of interest and reported information reflect the entire advancement of Radiology throughout the world and, indeed, several Cincinnati physicians did enjoy national reputations in radiology.

Another purpose of this review is to gather the material of the Cincinnati Radiological Heritage in one location so that historians or other interested parties in the future will not have to rework their way through the dusty archives of the past. Still another purpose is to stimulate the gathering of similar information in other communities before this material either becomes impossible to obtain or impossible to corroborate from our early practitioners.

Most of the information used in this review is from the *Journal of The Cincinnati Lancet Clinic* (1895-1910), a weekly journal of medicine and surgery as related to Cincinnati and its practicing physicians and issued during these years from an office at 317 West 7th Street, downtown Cincinnati.

1895 - 1898

The first official mention of the x-ray in the *Cincinnati Lancet Clinic* was February 22, 1896, approximately three months after its announcement to the world by Professor Roentgen in December, 1895. The editorial "Roentgen's Photographic Discovery" said

this new potential in photography which was outlined in Professor Lloyd's "Etiorpha" (John Uri Lloyd — "End Of

The Earth" — "a strange book with mysticism and occultism interwoven with speculative fancies") with so much definiteness months before Roentgen made his discovery known is attracting the attention of the entire scientific world.

The editorial continued with prophetic astuteness "so important is the discovery that it is hard to comprehend its limits, in fact we can only surmise incorrectly."

The first physician to give a talk concerning x-ray in Cincinnati was Dr. S. P. Kramer, who, on February 24, 1896, read a paper to the Academy of Medicine of Cincinnati entitled "Some Results With The Roentgen Process." This paper was published March 7, 1896, in the *Cincinnati Lancet Clinic* as the first printed paper in Cincinnati concerning x-ray. Dr. Kramer had secured an evacuated tube from McIntosh Company of Chicago and very sensitive plates from Mr. Smith, a Fifth Street photographer. His source of high potential, a Ruhmkorff coil, was unsuccessful and Dr. Kramer secured a static machine from Dr. Zenner, which proved more reliable. His first negative was that of a metal key taken through a piece of cardboard and requiring an hour's exposure. On the first exposure, the metal key appeared black on the paper, rather than white (reversal of image), and repeating the exposures with shorter and shorter times, he was finally able to obtain a white image of the key and other objects with a five-minute exposure (Fig. 1).

Dr. Kramer then turned to the use of Leyden jars as a source of potential and was able to cut down the exposure time still further and obtain a picture of the hand in two minutes. The developing of this glass plate required up to 30 minutes time. His article concluded

for obvious reasons, if it requires an exposure of a half hour or an hour or two hours, it will not be of much service to medicine, but if it can be reduced so that the thickest parts of the body may be penetrated within 10 minutes (!), it would be of the greatest value to us.

In March, 1896, the *Cincinnati Journal* reported the demonstration of Professor Kissling of Hamburg "of clear photographs of the embryo in its mother's belly." The well known cartoons and jokes concerning the new ray were appearing in the news-

*Dr. Lucas, Cincinnati, is Radiologist, Jewish Hospital; Attending Radiologist, Cincinnati General Hospital; Assistant Clinical Professor of Radiology, The University of Cincinnati College of Medicine.

Submitted October 24, 1966.

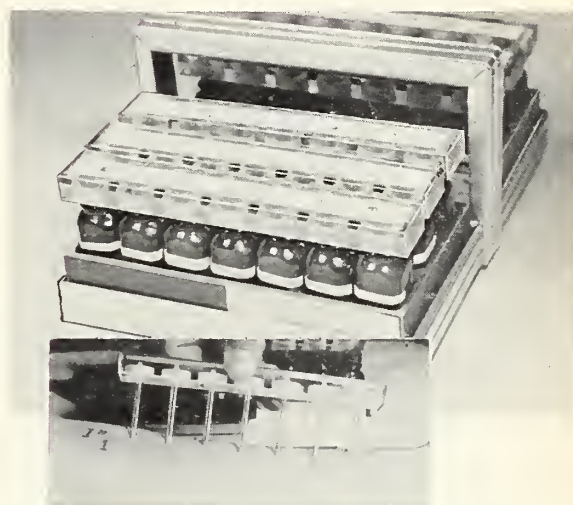
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NEW SPACE-SAVING PACKAGE

Allergy Laboratories of Ohio, Inc. has devised a new package to speed your prescription and reduce space requirements. The four vials are packed in a convenient window-clear plastic box with patient's name, and prescription numbers, face up. The bulky corrugated mailer box is thrown away after you've received your prescription.

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papers and journals. For example, there were the reports of husbands seeking x-ray photographers to use their camera which takes pictures across opaque substances to spy on their wife's bedchamber when suspected lovers were with her.

In September, 1896, a review of the book *The Medical and Surgical Uses of Electricity* by Dr. A. D. Rockwell, William Wood & Company, New York, mentioned the inclusion of a chapter devoted to the

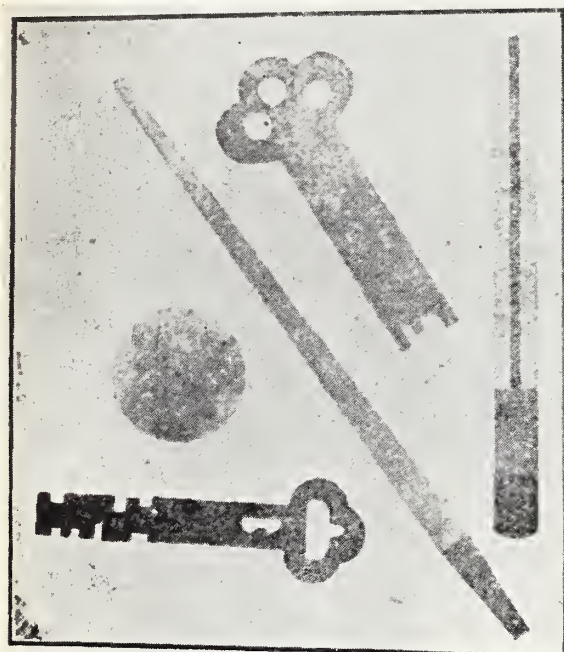


FIG. 1. First published x-ray in Cincinnati (1896). Film taken by Dr. S. P. Kramer requiring a five-minute exposure and taken through a 1 millimeter thick cardboard. The Cincinnati Lancet Clinic.

roentgen or x-ray. In May, 1897, the *Cincinnati Journal* reported an able paper of Dr. N. S. Scott of Cleveland concerning x-ray injuries and already demonstrating that harmful results would follow when an x-ray operator was not skilled in his work.

The first x-ray or skiagraph diagnosis of a pathological condition published in Cincinnati was in June, 1897. Dr. N. P. Dandridge, a noted genitourinary surgeon and at one time Professor of Surgery at Cincinnati Hospital reported a sarcoma of the fibula and demonstrated in both the frontal and lateral projections.

Toward the end of 1897 and 1898, there were reviews of the earliest reports of the therapeutic use of the x-ray in such conditions as hairy nevus and lupus. The work of Drs. Boas and Dorn, (reported in *Deutsch. med. Wschr.*), using ordinary gelatin capsules filled with metallic bismuth and followed through the alimentary tract by the roentgen ray was reviewed in the *Cincinnati Journal* in June, 1898, and was the first notice in this area of the artificial introduction of opaque medium. In October, 1898, Dr. William Gray of the Medical Museum of Washington noted the military use of x-ray in gunshot wounds and stated that

in all future battles, experts in skiagraphy will be attached of necessity to the Medical Corps. . . . We took out bullets by the pint on board the *Relief*, and almost without exception, they were located by the x-ray.

Dr. B. M. Ricketts of Cincinnati, later author of a series of surgical texts, presented in the *Cincinnati Lancet Clinic*, November, 1898, a radiograph of a hand containing the fragments of a needle, and the importance of localizing metallic foreign bodies by x-ray was easily recognized.

1899 - 1902

The legal problems regarding x-ray appeared early. In May, 1899, there was reported in the *Cincinnati Journal* a suit in Chicago with the awarding of \$10,000 to Frank B. Balling for x-ray burns necessitating three amputations of his foot. The defendants were Drs. Schmidt and Fuchs of Chicago. The suit was filed in 1897 for \$25,000 and required over two years before decision was made. This was apparently the first case for alleged damages resulting from the application of Roentgen's discovery. The claimant said the radiographers made three exposures from 40 to 45 minutes apiece and claimed that the x-ray machinery had been placed too close to the limb of which the "shadowgraphs" were taken. Judge Chetlain refused to allow an exhibition of the x-ray machine, a "mysterious" Crookes tube, in court.

The *Cincinnati Lancet Clinic* in 1899 reported the publication of the first journal devoted entirely to x-ray, *Archives of the Roentgen Ray*, issued in London by the Rebman Publishing Company and sold in this country by W. B. Saunders of Philadelphia at \$1.00 per issue. "Casually one would scarcely think it possible to get out a serial publication devoted exclusively to the subject of the Roentgen Ray."

Dr. Mark A. Brown, Professor of Physical Diagnosis at Miami Medical College in Cincinnati and later Professor of Medicine at the University of Cincinnati, stated in a 1900 editorial

in the case of every new discovery, the tincture of time and the essence of patience are necessary to determine everything before it, and statements of the most rash are given universal credence. So it is and was with x-ray.

He continued,

and yet the skiagraph may tell but a portion of the truth, as so beautifully shown 2 weeks ago. A doctor exhibited two skiagraphs of fracture of the forearm taken in different planes and in different positions of the arm. In one, the result was all that could be expected, and the other a very considerable deformity existed.

He went on to say

Dr. J. William White, Chairman of the American Surgical Association Committee on the medico-legal relations of the x-rays wrote in the *British Medical Journal*, April 21, 1900, "as to the question of deformity, skiagraphs alone, without expert surgical interpretation, are generally useless and frequently misleading."

He also warned "that callus in which no lime salt have yet been deposited will not show in the skiagraph."

(To Be Continued in July Issue)

AMA Sponsors Medical Journalism Award Contest for 1967

The American Medical Association has announced its fourth annual \$5,000 medical journalism awards program "to recognize journalism that contributes to a better public understanding of medicine and health in the United States."

Awards of \$1,000 each will be presented for outstanding reporting on health and medicine in five categories — newspapers, magazines, radio, television, and newspaper and broadcast editorials, reported F. J. L. Blasingame, M. D., Executive Vice-President of the AMA.

Categories of competition are:

1. **Newspapers:** For a distinguished news or feature story or series in a United States newspaper of general circulation published daily, Sunday, or at least once a week. Sunday supplements with nationwide circulation will be considered in the magazine category.

2. **Magazines:** For a distinguished article or articles in a United States magazine of general circulation published weekly, monthly, quarterly, or at other regular intervals.

3. **Editorial:** For distinguished editorial writing in a United States newspaper of general circulation

published daily, Sunday, or at least once a week, or on a U. S. radio or television station or network.

4. **Radio:** For distinguished reporting on medicine or health on a United States radio station or network.

5. **Television:** For distinguished reporting on medicine or health on a United States television station or network.

The awards will not be given for work, however excellent, that involves primarily the relaying of medical knowledge to the medical profession or to allied professions. Members of the medical profession, medical associations and their employees are not eligible to submit entries.

Dr. James L. Schamadan, Geneva physician, has accepted an appointment as associate professor on the faculty of Arizona State University, where he will teach biomedical engineering. Dr. Schamadan is coauthor of the text *Crash Safety Analysis*, and has written a number of papers on aerospace medicine.

Dr. Larry L. Hipp, Granville physician, was speaker for a luncheon meeting of the Granville Rotary Club, where he described his experiences as a health worker with Navajo Indians in Arizona. Dr. Allen Avery, another local physician, presided at the meeting.



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Ninth Specialty Council Added By Heart Association

Announcement has been made of the formation of a Council on Cerebrovascular Disease by the American Heart Association.

In making the announcement Dr. Lewis E. January, AHA President, pointed out that this brings to nine the number of scientific councils functioning within the American Heart Association as professional societies with subspecialty interests in the cardiovascular field.

The new Council will initiate and coordinate national and local programs of research, graduate and undergraduate medical education, allied professional education, public education and information and community services in the stroke field.

Council officers are Clark H. Millikan, M. D., of the Mayo Clinic, chairman; and John W. Goldschmidt, M. D., of Jefferson Medical College and Hospital, Philadelphia, vice-chairman.

The Association's eight other Councils cover arteriosclerosis, basic science, cardiovascular surgery, circulation and renal diseases, clinical cardiology, epidemiology, high blood pressure, and rheumatic fever and congenital heart disease.

Four Cincinnatians Honored by Dermatology Organization

Four Cincinnati dermatologists were honored as past presidents of the Noah Worcester Dermatological Society at the 10th anniversary meeting held recently in Las Vegas. They are Drs. Alfred L. Weiner, Daniel J. Kindel, H. Jerry Lavender, and Lawrence C. Goldberg, all faculty members of the University of Cincinnati Medical Center Department of Dermatology.

The Noah Worcester Dermatological Society was organized and founded in 1958 by Dr. Weiner in conjunction with UC's department of dermatology. He served as its charter president in 1958 and 1959.

The society's name reflects its Cincinnati origin and its early association with UC, memorializing Dr. Noah Worcester who was a faculty member of the Cincinnati Medical School from 1838-1846. Dr. Worcester distinguished himself and the school by writing and publishing the first American text book of dermatology in 1845.

Dr. Daniel F. Richfield, Cincinnati, is secretary-treasurer of the organization. Drs. Richfield and Weiner are exofficio members of the board of trustees and Dr. Mitchell Ede of Cincinnati is a board member.

The American Society of Anesthesiologists is offering its second annual journalism awards for articles in newspapers or general circulation magazines from July 1, 1966 to June 30, 1967. Deadline is August 1, 1967. Details may be obtained from the society at 551 Busse Highway, Park Ridge, Illinois 60068.



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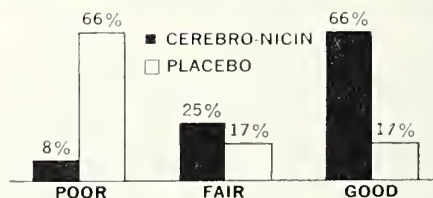
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*A Double-Blind Study of Cerebro-Nicin, Therapy for the Geriatric Patient, R. Goldberg, Jnl. of the Amer. Ger. Soc., June, 1964.

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Scientific Section

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No. 6

The Multiple Injury Patient Seminar on Emergency Room Management

By THE COLUMBUS, OHIO TRAUMA COMMITTEE OF THE AMERICAN COLLEGE OF SURGEONS
and THE DEPARTMENT OF MEDICAL EDUCATION, RIVERSIDE METHODIST HOSPITAL

REALIZING the need for house officer training in the care of the multiple trauma patient in the emergency room, the Columbus, Ohio Trauma Committee of the American College of Surgeons presented its first annual Trauma Seminar. This meeting was held at Riverside Methodist Hospital in conjunction with the Riverside Methodist Hospital Educational Program and was arranged by Dr. Philip H. Taylor, Area Chairman, Committee on Trauma, with the cooperation of Dr. Francis P. Kintz, Director of Medical Education, Riverside Methodist Hospital.

The purpose of this program was to improve the care of trauma victims in this area. Although many of the hospitals had previously given emergency room care lectures, it was felt that a city or area-wide program, presented by trained persons, would be stimulating and more productive. We know that the new house officer particularly needs instruction about the many facets of trauma. Therefore, the meeting was held in early July in an effort to get the neophyte, who would be attending these patients in the emergency room, started correctly.

A simulated patient, an intern made up as a multiple trauma victim by an expert (Fig. 1), was rolled in front of a panel of experts. This very fine panel (Fig. 2) was moderated by Col. John Moncrief, Chief of the famed Surgical Research Unit, Fort Sam Houston, Texas.

* * *

COL. MONCRIEF: As Dr. Taylor said, we intend to discuss the problems of the multiple injury patient, not from the standpoint of his ultimate rehabilitation, but from the standpoint of his immediate care, what one does for this patient, and how he evaluates him when he first comes into the Emergency Room, and the immediate care that is necessary in order to assure his survival.

DR. FLORA: Dr. Moncrief, we heard there was a Trauma Seminar here this morning, and we have a complicated case right here in the E.R. that we need considerable help with, and if you don't mind, we'd like to bring the patient in.

DR. MONCRIEF: Bring him right in. We've got a bunch of experts here that should be able to help him out.

DR. FLORA: This is a typical young American male, approximately 28 years old, who was at a bachelor party last night and early this morning ran his late model convertible into a bridge abutment. That was about an hour and a half ago, and shortly thereafter he was picked up and brought to our Emergency Room. My Intern here, Dr. Kneer, was on call last night and he saw the man first. The patient was conscious and moving all his parts. His blood pressure was about 90/40, and his pulse was 140. His respirations were rapid, and shallow. He was in extreme agony from all these injuries, which you see, and Dr. Kneer gave him a quarter grain of morphine. He drew some blood for type and cross match and started an I.V. of dextrose and water

This program was made possible by reason of the financing from Smith Kline & French and Merck Sharp & Dohme Companies.

through a scalp vein needle, and then he called me down to see the man.

You can see most of the injuries he has. He has a large hematoma in the left temple area with a large laceration vertically over the left side of the face; there's a depression over the right maxillary area. His mandible swings freely in the breeze. There was a lot of blood and secretion in his pharynx when we first saw him and he was kind of strangling and cyanotic, so we almost trached him, but didn't. He wasn't breathing well at all, and there were no breath sounds on the right side of his chest, where he also had a lot of contusions. There was some emphysema above the root of his neck—we couldn't really explain this, but we thought it was probably a flail chest type of thing because the right side of his chest didn't move with the left side.

He had some contusions over his upper abdomen. It was quite soft, though, and he had a few bowel sounds. Down in the right lower quadrant and in the right groin we've got more problems because there's a big hematoma down there, and it keeps getting larger. We put a catheter in him and got some bloody urine as you can see here. In addition to the abrasions and lacerations of the extremities, there is a compound fracture of the left femur here, and I can't feel any pulse in his left foot. Well, we didn't know what to make of all this, so we got a bunch of x-rays: skull films, facial bone films, cervical spine, ribs, dorsal spine, PA chest, two views of the abdomen, pelvis and all four extremities.

While he was in x-ray, we went to breakfast, but we came back and he didn't look quite the same. He wasn't moving quite as well as he was before, and his left pupil was a little big, and his right side was kind of flaccid. He was a lot quieter, but his airway wasn't any better. He was still kind of shocky, and we didn't know exactly what to do because the blood wasn't ready yet, so we hung a bottle of Levophed®. We've been running that as fast as we can, and his blood pressure is up a little bit better now. I understand the x-rays are back; maybe Dr. Briggs would like to show us those.

DR. BRIGGS: As you might expect with a patient so severely injured, the first time around may not give us all the information they want, but they do show us quite a bit that is going on. First the lateral projection of the skull shows a linear fracture—this is in the left temporal frontal area, as we would expect crosses the general area of the anterior branch of the middle meningeal artery. Films in frontal projection of the face suggest there is a depressed comminuted fracture involving the right zygoma. There is a fracture separation through the inferolateral wall of the left antrum which involves the floor of the orbit. The lateral projection suggests that these structures, primarily the maxillo-facial portion of the face is depressed perhaps 1½ cm.

In the chest we see multiple rib fractures, predominantly involving the right rib cage; starting with rib No. 3 there is a single fracture, ribs No. 4 down through No. 8 are fractured at least two places. We see fluid accumulation in the right pleural compartment, certainly we would expect this to be blood. There is air extending around the lateral chest wall; without an open chest wound we would expect this to have come from a ruptured lung. This is a recumbent film so we don't see fluid levels or definite pneumothorax. There is extensive air dissecting into the neck and out the superior mediastinum. The film of the abdomen—particular attention is directed to the left upper quadrant; we fail to identify the usual cleavage plains between the soft tissue organs, particularly we are concerned about spleen. Examination of the pelvis showed extensive comminuted fracture involving the ileum and ischium on the right side, with a protusion of a segment of the ischium into the pelvis. Contrast was introduced into the bladder; this confirmed perforation of the bladder. Films of the left femur show midshaft transverse fracture not obviously compound from the x-rays, but clinically so.

COL. MONCRIEF: Thank you very much. Would any members of the panel like to examine the patient a little more closely than they can sitting up there at the table so they can determine what his problems really are, or ask any questions of the Doctor who presented his initial history?

It is the job of the Moderator of the panel, in Dr. William Altemeier's description anyway, to be like a eunuch in a harem. He is supposed to supervise the activities thereof but not to partake therein. So it is to be my job this morning to try to guide the panel in their discussion of this patient's problems in a way we hope will be of some enlightenment to members of the audience. There must at all times be some individuals who have the primary responsibility for the care of the patient, and this varies from place to place; depending upon what facilities are available and who is willing to take this responsibility. In many instances, however, this responsibility falls upon the General Surgeon. Dr. Zollinger, being the General Surgeon and head of the team here, what would be your initial evaluation of this individual? As mentioned in the presentation, this patient when first seen was somewhat restless, although alert. He was given a fair amount of sedation, a quarter grain of morphine, a scalp needle was inserted, and some dextrose and water was started. Would you comment on the initial care of this patient, and the subsequent events that probably followed?

DR. ZOLLINGER: The essential thing is not to panic. Actually, there are certain basic principles to follow. After arrival at the Emergency Room you should, if possible, get a history from the police or whomever was responsible for the patient's trans-

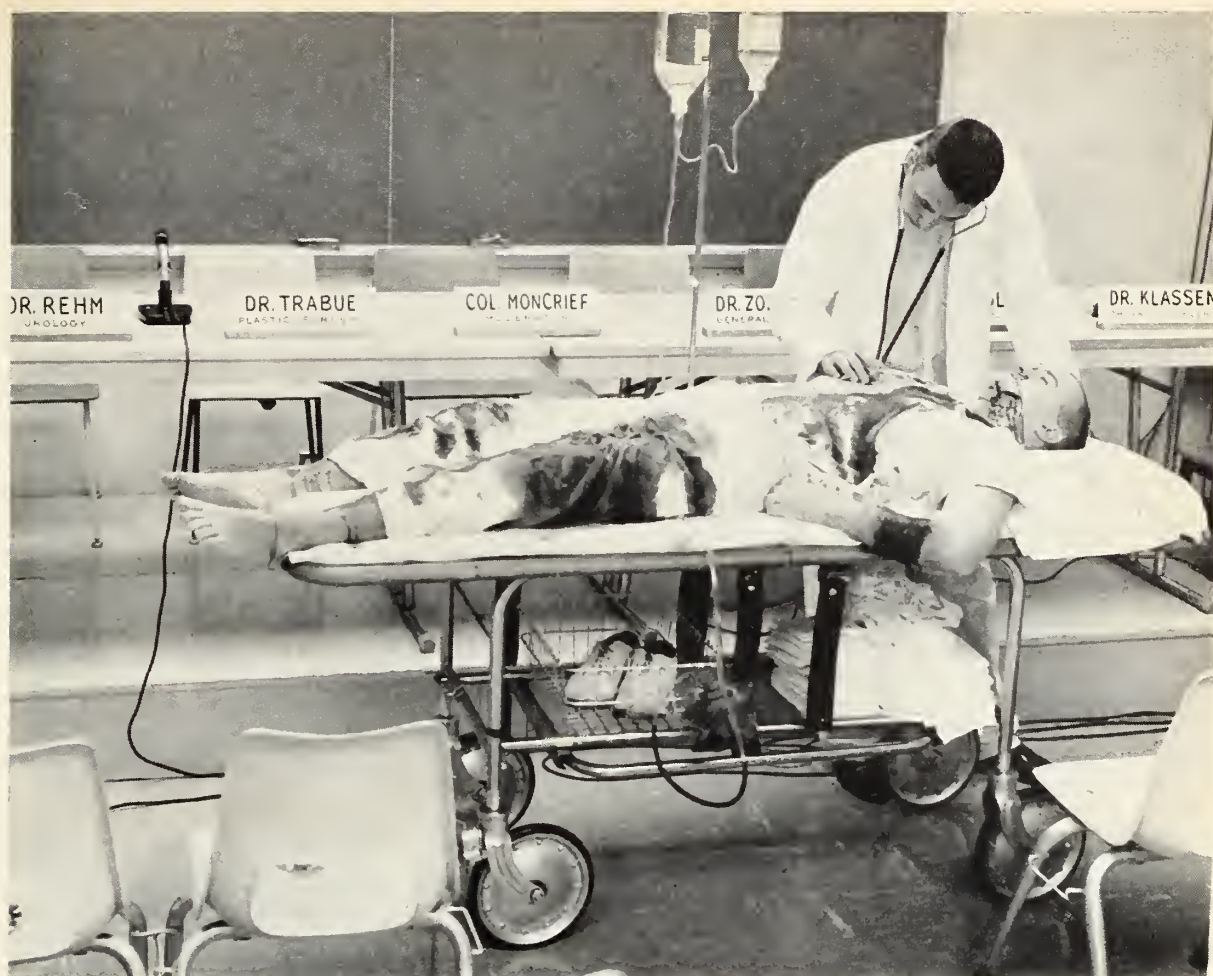


FIG. 1. *The simulated multiple-injury patient.*

portation. This history should be recorded. It should include the mechanism of injury.

The basic principles include the general principles of resuscitation and management. First, the patient must have an adequate airway. Second, all obvious bleeding areas should be controlled. Third, there should be a rapid general survey made of the patient and notations made of these general findings. This is very important because so often our attention is attracted by a seriously appearing external injury causing us to overlook signs and symptoms of a more serious internal injury.

The survey should start at the head and proceed downward, which should include some idea of the patient's state of consciousness, whether there is blood or spinal fluid exuding from the nose or ears, and the status of the patient's pupils. The chest should be rapidly inspected for possible fractures, pneumothorax, hemothorax, or open wounds. The original abdominal examination should be noted and this examination should be repeated periodically, because only by careful examination can we get an indication of early changes and diagnose serious internal injuries. The urethral and anal areas should be in-

spected for hemorrhage. All extremities should be carefully examined for fractures and dislocations and whether the patient has the ability to move his extremities, because this may give us an idea of spinal injury with associated cord injury. Such a rapid survey obviously will prevent us missing a serious injury.

COL. MONCRIEF: This takes a long time though, Dr. Zollinger, and you've been going over this patient from top to bottom. You do it quite hurriedly that's true, but it still takes time. How do you decide what to do first?

DR. ZOLLINGER: Well, I don't think there is any question but what an adequate airway is number one. That is all-important.

COL. MONCRIEF: This man was hurting quite a bit and the first thing that was done was to consider his pain—he was given a quarter grain of morphine.

DR. ZOLLINGER: Obviously, this man shouldn't have a large dose of morphine as he had all the signs and symptoms of shock. In the first place he wouldn't be likely to absorb the medication because of the shock and once he had responded to shock

he may rapidly reabsorb this large dose of morphine and create a confusing clinical picture. If I were to give morphine I would give a small dose, perhaps an eighth, and I would give it intravenously.

COL. MONCRIEF: This would be a pretty unusual hospital if you had blood available typed and cross matched as soon as he came into the Emergency Room. What would you recommend that this patient be given as soon as he comes in? In most hospitals it takes 20 to 30 minutes to type and cross match blood adequately.

DR. ZOLLINGER: I would start plasma or dextran.

COL. MONCRIEF: Give him some type of volume expander anyway, whether it be a colloid such as dextran or plasma, or you could even give him salt water. If you give them enough salt water (this means running it in pretty rapidly in large volumes) you can resuscitate these people quite adequately. Dr. Klassen, Dr. Zollinger has mentioned that you've got to assure an adequate airway in this patient. I don't see much wrong with his airway—his throat isn't cut, just the side of his face, and he looks like he can breathe on at least one side of his chest. What's the problem here?

DR. KLASSEN: The patient deaccelerated rapidly and he may have multiple injuries. He may have rupture of his trachea or bronchus and laceration of the thoracic aorta. Before we determine this we must make sure that he does have a clear airway. This should be done before we consider the administration of various intravenous solutions and even before we take x-rays. We should look at his airway now.

COL. MONCRIEF: You mentioned oxygen. This fellow was pretty restless when he came in and this morphine really didn't calm him down too much. He still remained restless.

DR. KLASSEN: He needs oxygen, which explains his restlessness. His difficulty is hypoxia. He may have an obstructed airway from aspiration of previously ingested food.

COL. MONCRIEF: Do you mean that if the patient can't breathe very well, he's going to be restless?

DR. KLASSEN: That is right.

COL. MONCRIEF: Yes, I think it's very important to realize that restlessness is one of the earliest symptoms of hypoxia.

DR. KLASSEN: Let's look at his larynx, trachea and bronchi since we want to establish a clear air-



FIG. 2. The panel of discussants.

way. We should use a laryngoscope and may possibly need a bronchoscope. Laceration of the trachea and rupture of the bronchus can be visualized by endoscopy. We can also remove foreign material from his trachea and bronchi, which he may have aspirated during or immediately after the accident. We should next have the anesthesiologist introduce a cuffed tube into his trachea which will then allow us to control his respiration.

COL. MONCRIEF: How long are you going to leave this cuffed tube in there?

DR. KLASSEN: This tube can be left in place for half an hour or 24 hours without difficulty.

COL. MONCRIEF: How will you decide whether or not he needs a tracheostomy? He doesn't have his trachea obstructed.

DR. KLASSEN: We should not do a tracheostomy as a first step because the anesthesiologist can control the patient's respiration very nicely with an intratracheal tube. He can give him morphine at this time, if this is necessary, although the patient usually will not need it. They are too sick and we have too many other things to worry about now.

COL. MONCRIEF: Yes, but when you look at this fellow, one side of his chest is going out and the other side of his chest is going in at the same time. Is it supposed to work this way?

DR. KLASSEN: This patient has a flail chest. This can be controlled quite well by leaving the intratracheal tube in place and by giving him a mechanical oxygenator, which will control the paradoxical motion of his chest wall.

COL. MONCRIEF: Suppose there's something wrong with your respirator and you can't give him intermittent positive pressure? Is there anything else you might be able to do that would help this fellow exchange better?

DR. KLASSEN: We have for many years used towel clips which are applied to the sternum or to the ribs in case of flail chest and by using pulleys and a counterweight we can stabilize the chest very well. Another way is to use sandbags or lead bags and place them against the flail chest so that it will stabilize the thoracic wall, and in this way, the patient will have fairly good respiratory exchange. After all, this patient is a young person. He has normal lungs. We can actually obstruct one lung completely or have it not functioning without the patient having too much difficulty, as far as respiration is concerned. I still think that endotracheal administration of oxygen is the best way of handling this patient in the initial phase of his evaluation. The anesthesiologist can do this for a long period of time.

COL. MONCRIEF: That would be a lot of work on the part of the anesthesiologist.

Panel Participants

● Col. John Moncrief, MC, USA, Panel Moderator, is Head of the Surgical Research Unit at Brooke General Hospital, Fort Sam Houston, San Antonio, Texas.

● James E. Barnes, M.D., Columbus, Clinical Assistant Professor of Surgery (Neurosurgery), The Ohio State University College of Medicine, is a member of the Senior Attending Staff, Riverside Methodist Hospital, and Attending Staff, University Hospital.

● Carl R. Coleman, M.D., Columbus, Assistant Professor, Division of Orthopedic Surgery, The Ohio State University College of Medicine, is a member of the Senior Attending Staff, Riverside Methodist Hospital, and Attending Staff, University Hospital.

● Karl P. Klassen, M.D., Columbus, Professor of Surgery, The Ohio State University College of Medicine, is Director of the Division of Thoracic Surgery, University Hospital.

● Robert A. Rehm, M.D., Columbus, Instructor in Urology, The Ohio State University College of Medicine, is a member of the Urology Attending Staffs of Riverside Methodist Hospital, and University Hospital.

● John Charles Trabue, M.D., Columbus, Plastic Surgeon, is Chairman of the Department of Surgery, Riverside Methodist Hospital.

● Richard W. Zollinger, M.D., Professor of Surgery, The Ohio State University College of Medicine, is Chief, Department of Surgery, Mount Carmel Hospital.

DR. KLASSEN: Oh, they don't mind.

COL. MONCRIEF: Well, the gas passers around here are different from the ones we have. This is an awful lot of work for this fellow. You mean you're going to have this fellow sit down and squeeze this little black bag for two or three days on this fellow until his ribs heal?

DR. KLASSEN: No. No. We're talking now about the first 24 hours—actually, we're talking about the first 10 minutes.

COL. MONCRIEF: Are his ribs going to stabilize in 24 hours? He's got all his ribs fractured on one side. Ordinarily they're not going to heal in 24 hours or so. The initial thing that you're going to do for this fellow is to maintain a patent airway, certainly, but how's he going to breathe after this?

DR. KLASSEN: That mediastinum is not particularly shifted on the x-ray film. He will do fairly well even though he has paradoxical motion on that side. We could give him support by putting sandbags on that side and supporting him in one position even if we've cut the function of that right lung

fairly much. I'm talking about the x-ray now. Since we don't know what his intrathoracic lesion is, this is the most important thing. We should do a thoracentesis and see if he has free blood in the pleural space.

COL. MONCRIEF: Suppose he's got blood in there. What are you going to do—stick a needle in him every half hour or so?

DR. KLASSEN: No, if he has blood in his pleural space, I would insert an intercostal tube—a good-sized tube—a No. F26 or better. Put it between the ribs under local anesthesia. Put on the water bottle seal and see what happens. If he keeps bleeding and loses a great deal of blood then open the chest.

COL. MONCRIEF: What do you mean by a "great deal of blood"?

DR. KLASSEN: If he loses more than 500 ccs in the first hour or so I'll do a thoracotomy on him.

COL. MONCRIEF: Well, this fellow hasn't lost that much blood and probably won't in the next 24 hours but every time he takes a breath it hurts and he just doesn't want to breathe very much. What are you going to do about this?

DR. KLASSEN: A young man like this, I wouldn't worry about it too much. I would support his chest on that side with counter-traction or sandbags.

COL. MONCRIEF: Suppose this fellow is 55 years old. He's not quite such a young fellow and he still hurts every time he takes a shallow breath.

DR. KLASSEN: Then I would use an intercostal Novocain block—that's probably what you're looking for.

COL. MONCRIEF: You may be 50 or 75 miles away from one of these things and this fellow's turning blue all the time.

DR. KLASSEN: During this time? About his flailed chest. Are you still worried about that?

COL. MONCRIEF: He's got a flailed chest and he won't breathe even on his good side because it's hurting too.

DR. KLASSEN: Well, I would—I don't think it hurts him that much. With all the other injuries he has I don't think his chest will bother him too much, really.

COL. MONCRIEF: The point I was trying to bring out is that there are patients who do have, with rib fractures, rather severe pain which, in addition to the flailed chest may be enough to make them decompensate and if you can block this pain in some way—either by intercostal blocks, or, in some cases if they're injured as much as this patient and he has injuries every place—one might even try an epidural after he has been adequately resuscitated with volume replacement therapy. One would not try this until volume replacement has been secured. Dr. Trabue, this fellow is a very nice young fellow and he has

many years to go yet and his face looks like it's a mess. Don't you want to be the first one at him and take him up to the operating room? You've got to fix him up so he can go out to the dance next week.

DR. TRABUE: They'll have to catch me first. The point that you're trying to make and the point that I want to make here is that this certainly is the last thing on the ladder. I would say that we must consider breathing and bleeding and, as the third "B," brevity. The only point I want to contribute here this morning is that you must be brief in the assessment of the maxilla facial situation and not send this patient to x-ray for complicated views at three o'clock in the morning. As Dr. Flora brought out, this patient will die while he's getting all these x-rays taken. You've got about 10 or 15 days to take care of his fractured mandible and his fractured maxilla. It is important, of course, to stabilize the displaced, bony, fragments of the face, primarily in terms of an airway. In maxilla facial injury, fractured mandible—a compound fracture of this type, where the tongue is not stabilized by the bony ring of the mandible, if you think the patient needs a tracheotomy, he certainly needs one. There's no question about that. His tongue will fall back and he'll strangle to death for he can't handle his secretions. Now that does not mean that you need to put complicated arch bars on him—just some sort of supportive therapy; a Barton dressing, something to hold the mandible forward would be the thing to do in this specific case.

The other thing, of course, in terms of maxilla facial surgery: this patient's greatest enemy is the doctor with the sedative needle. These patients will walk into the emergency room holding their face in their hands as they've hit the dashboard. As long as they can sit up, get their face forward, spit the blood out and spit their secretions out, they'll breathe and they'll live. The minute they lie down flat in the emergency room somebody gives them morphine; all the bone fragments fall back, their tongue falls back in their throat, and they're dead in three minutes. You must avoid sedation in this particular type of case, and barring other injuries, if he wants to sit up and can sit up, let him do so. Restlessness in this case, until proven otherwise, has to be sheer anoxia.

As far as his laceration is concerned, I want to make one brief point here. Don't get panicked into using three or four of major sutures of 3- or 2-0 black silk to slap these tissues back together. Again, you're doing him a favor if you simply put a Band-Aid on it and wrap it up and fix it two or three days later if you have to. I mean, visualize this in terms of the patient. It's ridiculous to put in 5,000 little 6-0 nylon sutures in a laceration of the face on this guy and five days later you're going to be using crowbar and pickax work to get his

bones straightened around. So suture his laceration primarily to stop bleeding and reapproximate displaced tissue. This would be your goal. Again, let me say that brevity is the key to his management. Don't spend four or five hours sewing up this gentleman's laceration. You're doing him a favor if you put a Band-Aid on it and walk away from it.

COL. MONCRIEF: Would it be fair to say, then, that you're not interested so much in the cosmetic appearance as you are in keeping this fellow alive and making him a functional individual?

DR. TRABUE: I do hate to say that. It goes against every precept of my training, Colonel, but I'll have to agree.

COL. MONCRIEF: Fine. Well, Dr. Barnes, it doesn't seem like anybody wants to get this fellow first. We have all been saying that when a fellow has a squashed head that you're supposed to rush in and take care of this real fast and do something about it. This fellow has a fracture on the side of his head and it goes right across where his middle meningeal artery is. Don't you think this is a real emergency for the neurosurgeon to be called in, and open this fellow's head up right away?

DR. BARNES: Yes, as a matter of fact, I do.

COL. MONCRIEF: How soon? He's still lying here on the table and you haven't made a move at him yet.

DR. BARNES: It's too late. He's dead. Face-tiously perhaps, but he couldn't have lasted this long. There's no question that the most important thing is a patent airway and the next most important is to make sure that he's not bleeding to death. They did establish a base line of level of response when he came in, and noted that he was moving all his parts. That's a rather vague base line but better than none. They did notice that, when they came back from breakfast, he had a left temporal hematoma, a dilated left pupil and a right hemiparesis. Now you can't get around the fact that this is a significant change from what he had before. It's significant enough that perforation openings need to be done immediately and without wasting precious time for x-rays, EEG, echoencephalogram, or an angiogram. He has a mass lesion, probably a hematoma in the epidural space and originating from a torn middle meningeal artery. He's getting worse, his level of consciousness is going down, he has lateralized. The hematoma is enlarging rapidly and taking his life. He's not bleeding to death. He is dying because of pressure, and somebody has to put a hole in his head and "let out the bad blood." This is what's killing him and he needed to have it done three hours ago.

COL. MONCRIEF: Let's think of another hypothetical patient. Suppose the patient comes in and he has a depressed skull fracture and it's in his left occiput and he has no neurological signs. Where

then would you place his neurological treatment in the priority of this patient?

DR. BARNES: The type of injury is of much less significance than the progression of neurological deficit. If he has an open, depressed fracture of the occipital area with brain and blood coming out and has other injuries such as bad airway with associated hemorrhage he's in shock, then I can wait. I can wait for hours to fix that because he's "decompressing himself." He's not dying from pressure. Why do people die from head trauma? Because of increased intracranial pressure. They don't die of shock from bleeding from the vessel. They die of increased pressure.

COL. MONCRIEF: Would you mean, then, that unless his symptoms are progressing that putting holes in his head does not take immediate priority?

DR. BARNES: Absolutely correct.

COL. MONCRIEF: I think this is important to bring out because many people think that if the individual has a skull fracture or a depressed fracture, or, as Dr. Barnes says, part of his brains are hanging out that the first thing you have to do is to take him to the operating room; neglect everything else and fix his head. Unless he's getting a progressive neurological deficit he is not a neuro-surgical emergency, under these circumstances, compared with the other things that he may have.

DR. BARNES: Colonel, let me make a couple other points in regard to this, if I may. A few "don'ts" that were done: *don't* give him large volumes of fluid unless you're giving it because he is in shock. This causes increased cerebral edema. *Don't* give him narcotics or sedatives. *Don't* do superfluous studies, such as extensive x-rays at three o'clock in the morning on a patient who is dying. You do establish a base line, just as they did. Again, once significant signs appear that indicate a surgical lesion, you move, you move right then.

COL. MONCRIEF: Dr. Coleman, you and Dr. Rehm will probably have to get together on this fellow. I don't know how often you do that, but here's a fellow who has a fractured pelvis and he's putting out bloody urine and he's got a fractured leg. Don't you think these things are important? What priority would you give to taking care of these things?

DR. COLEMAN: I think the priority given is the proper one. The orthopedic problem should come fairly far down the line. A good axiom to remember is that people do not die from fractures, they die from the complications of a fracture. The fracture per se is not a deadly device. The fractured pelvis is by far the most important orthopedic injury on this patient. The compound fracture is more colorful and much more dramatic. Associated with the compound fracture is the possibility of vascular injury. Vascular injury, however, is more commonly seen in supracondylar fractures of the femur.

COL. MONCRIEF: He doesn't have any pulse in that foot, the doctor told us.

DR. COLEMAN: Correct. We'll return to that but the pelvic fracture should take precedence at this time. There is also a ruptured bladder to consider. The right hip should be treated with traction. The position is acceptable, although the patient may have some traumatic arthritis later. The important thing is to repair the laceration of the bladder.

COL. MONCRIEF: Well, Dr. Rehm, Dr. Coleman has thrown this back to you now. He says the bones aren't very important to this fellow at the moment, he wants something done about this hole in his bladder.

DR. REHM: Although his urologic problem is serious and requires surgical attention, the timing of this is important. I do need the help, particularly of the general surgeon and the orthopedic surgeon; I want to know if Dr. Zollinger believes this man has a ruptured spleen, since I have to establish suprapubic cystostomy and establish perivesical drainage.

COL. MONCRIEF: Does a ruptured bladder take precedence over a ruptured spleen?

DR. REHM: No, it does not. A ruptured bladder is a serious urologic injury and requires attention within a matter of a few hours, however it does not take precedence over the management of airways or blood loss.

COL. MONCRIEF: Suppose Dr. Zollinger has explored the upper half of his belly and his liver's all right and his spleen is all right, but this guy is still bleeding from somewhere. Where do you think he's possibly bleeding from?

DR. REHM: He is bleeding from his pelvic fractures, and he may lose several units from that alone. Severe blood loss from the bladder itself is very unusual.

COL. MONCRIEF: Do you mean that bones bleed?

DR. COLEMAN: The pelvic veins bleed as well as the blood supply to the bones.

COL. MONCRIEF: How do you stop it?

DR. REHM: Generally you can't control retroperitoneal hemorrhage of this kind; you just have to replace the loss. You cannot find the single bleeder.

DR. COLEMAN: In pelvic fractures such as this, one can lose up to 12 or 14 units of blood. Frequently these patients are operated upon with the thought that a spleen has been ruptured or that some large vessel has given way. Sometimes this is true but often upon entering the abdomen the first thing observed is that parietal peritoneum from the posterior aspect is against the anterior aspect of the abdomen. One may cauterize for two hours, still replacing blood in the patient, and finally close without stopping the bleeding. The blood loss would have tamponaded itself if the patient had been transfused. The closed treatment of a fractured pelvis is indi-

cated and the open treatment, of course, for the ruptured bladder.

COL. MONCRIEF: Dr. Zollinger, this fellow came into the emergency room after hitting a bridge abutment. He had just eaten a lot of food and come from a whingding of a party. He was really feeling good! He fractured his mandible and he fractured his maxilla. His belly's soft now but in a few minutes it's going to get a little firm and then it's going to get hard. He was driving the car. What would you be suspicious of in this individual and how would you approach it?

DR. ZOLLINGER: Originally, the abdomen was soft. But you say that in a matter of minutes, or perhaps an hour or so, there were changes. I think that you hit on the point here that the most important thing in evaluating whether a patient has possible internal abdominal injuries. It is essential that we do periodic examinations on the abdomen and note any changes. The history of the point of injury has not been listed but from what I see here from looking at the patient and from the x-rays, he has sustained fractures on the right side of the chest. With fractures on the right side and a flailed chest one should worry about liver injury.

COL. MONCRIEF: How would he get his liver injured? The steering wheel didn't go through his belly wall or anything. All he did was fracture some ribs and bust up his face. How did his liver get hurt?

DR. ZOLLINGER: If his right lower chest is compressed against the liver it could actually be exploded by compression.

COL. MONCRIEF: So he fractures his liver just like he fractures his ribs then.

DR. ZOLLINGER: That's right. A steering wheel injury may traumatize other organs also. We may find on repeated examinations that the patient is developing areas of muscle spasm, tenderness and rigidity in the epigastrium, the left upper quadrant, perhaps even a mass may be developing in the left upper quadrate, and the patient may complain of pain referred to the shoulder. In this case we begin to worry about the possibility of a splenic injury. The death rate from ruptured spleen with multiple injuries is very high. It's probably 25 per cent or better. The splenic vessels are quite large and the patient bleeds quite seriously from such vessels, so if hemorrhage does occur it is necessary that we do a splenectomy as soon as possible. The question of course is always whether one should do repeated abdominal taps to see whether there is evidence of internal hemorrhage. These are contraindicated if the abdomen has become distended or if the patient has multiple scars on his abdomen, because under these conditions you may enter the bowel. It is my opinion that we quite often get questionable taps

and so I have never been impressed with their value.

COL. MONCRIEF: Suppose your taps are all negative?

DR. ZOLLINGER: They wouldn't mean much to me. In other words I'm not tap crazy. I think you can get too many controversial findings with taps.

COL. MONCRIEF: Would it be safe to say that they're valuable in this situation only if they're positive?

DR. ZOLLINGER: That's right.

COL. MONCRIEF: What criteria would you use as to whether or not you would sit on this patient, figuratively speaking, and watch him or whether you would go ahead and open up his belly after his airway is taken care of and you resuscitated him as far as volume is concerned?

DR. ZOLLINGER: Of course, I may make a negative exploration. But the mortality from a negative exploration is practically nil as compared to a missed diagnosis, where if a certain injury has occurred the mortality rate is practically 100 per cent. In this patient's case he has numerous injuries that may have caused his shock. If shock is the result of an abdominal injury this will usually show up within a matter of hours. Shock developing after 12 hours may be due to toxic peritonitis, due to some break in continuity of the gastrointestinal tract such as the duodenum at the ligament of Treitz, or perhaps some injury of the terminal ileum at the ileocecal valve, or quite rarely an actual explosion of the ascending colon in the cecal area.

COL. MONCRIEF: In other words, you would rather explore him and find nothing than not explore him and find him dead later.

DR. ZOLLINGER: That's right. A negative exploration has a low mortality. A missed diagnosis of a severe abdominal injury has practically a 100 per cent mortality so there's no question here that a negative exploration is much better.

COL. MONCRIEF: Dr. Coleman, this fellow's got a bone sticking out of his mid-thigh over there. Don't you think you ought to take him up and stick a pin in there and get this thing in shape? What are you going to do about this fractured leg he's got?

DR. COLEMAN: This is quite an important injury. After his airway is established, the brain is cared for, the spleen repaired, the bladder repaired and just before Dr. Trabue comes onto the scene, we will do something about the compound fracture. The compound fracture should be treated within six to eight hours.

COL. MONCRIEF: You mean you're going to let this fellow lie there on the table, and be turned around and lifted up, his belly opened up and everything else and his leg's going to be flopping around all this time?

DR. COLEMAN: Yes moving, but not flopping! The femur will be splinted with skin traction or preferably skeletal traction through the distal tibia.

COL. MONCRIEF: Well why do you want to do this? This fellow's got a bone there and it can flop around some and it's not going to hurt that bone.

DR. COLEMAN: One should be concerned with the vascular injury possible with this type of fracture.

COL. MONCRIEF: You don't have to worry about that. He doesn't have any pulse in his foot now.

DR. COLEMAN: If the pulse being absent is not because of profound shock, then immediate investigation is indicated.

COL. MONCRIEF: You've got a pressure of 90 over 40.

DR. COLEMAN: The patient should have a pulse. Possibly by applying traction to the extremity the pulse may be returned. If the pulse doesn't return, then the vascular injury takes precedence over the osseous injury and both should be repaired at the same time. One should stabilize the fracture at the time the artery is repaired. If there is no arterial injury, debridement of the area and reduction without metal fixation of the femur should be performed.

COL. MONCRIEF: Dr. Zollinger, he may have to call on you here to take care of this vessel although Dr. Coleman may want to repair it himself, I don't know. Dr. Coleman has looked at his femur here and it's chewed up his femoral artery. This is a contaminated wound, it's dirty, he's lost blood, he doesn't have any pulse in his foot—what are you going to do for this fellow to save his leg?

DR. ZOLLINGER: There may be a hematoma surrounding the artery. The exploration of the point of injury may show that this is just a localized arterial spasm. Debridement of the area may release the spasm. If there is definite contusion or laceration of the area then one is going to have to resuture or replace a segment of the vessel. Now in a young man such as this, a small area can be removed, and if the vessel is elastic enough then the ends can be brought together and sutured.

COL. MONCRIEF: Suppose he's got about an 8 or 10 centimeter area here that is just gone somehow. He's got a dirty wound—are you going to take a piece of plastic graft and put it in this fellow to give him a good pulse down there?

DR. ZOLLINGER: This is a problem. The seriously injured leg will not have an adequate vein to be used as a bypass graft. A vein may be found in the good leg for replacement but it is questionable whether this much time can be utilized in such a seriously injured patient so it would probably be more practical to use a plastic graft. There is a chance, however, that this may become secondarily infected.

COL. MONCRIEF: We've got this patient here

and he's been pretty well worked over. The only problem is that he's still getting glucose and water by a scalp vein needle. While everybody's been manipulating him here and getting x-rays on him, his pressure's coming up—he's been given Levophed® and this has brought his pressure up real well. He looks a little pale and mottled in his extremities, but he's got a good blood pressure and the nurse thinks this is fine. His pressure is about 120 over 70 and he's doing pretty good. What are you going to do for him now?

DR. ZOLLINGER: Number one, we have to get an adequate vein and we may have to get more than one adequate vein. We have to find all we can and get fluid started to get adequate volume replacement. Actually, most people can lose a pint or they can lose a liter of blood without many clinical signs of shock. He has a blood pressure of 90/40, a pulse rate of 140, so we must admit that he has lost at least 20 per cent of his total blood volume.

COL. MONCRIEF: Yes, but he's getting Levophed—this is real good. . . .

DR. ZOLLINGER: Well, we can throw that out the window, because. . . .

COL. MONCRIEF: Oh, you don't like it?

DR. ZOLLINGER: I don't like it.

COL. MONCRIEF: What's the matter with it?

DR. ZOLLINGER: It contracts the peripheral bed and you're not replacing volume so there's going to be a lack of perfusion of distal tissues with accumulation of lactic acid and this man's going to end up in worse shape than he ever was.

COL. MONCRIEF: Are you saying that flow is more important than pressure?

DR. ZOLLINGER: That's right.

COL. MONCRIEF: Dr. Klassen, this fellow was going pretty fast and he stopped in a hurry when he hit this bridge or whatever it was that he hit, and it threw him up against the steering wheel and he fractured some ribs and you've taken care of his airway and stabilized his chest. Is there anything else you might be concerned about in this fellow when he stopped all of a sudden?

DR. KLASSEN: There are two interesting things. This patient could have a ruptured bronchus as I mentioned before. We should always keep that in mind and it's very easy to diagnose that. The other thing that's important is a rupture of aorta and this is a beautiful thing to see and recognize in the emergency room because you can do something for it. If you see a patient with a sudden deceleration like this patient—particularly the driver or a girl friend of his who is hugging him next to the steering wheel, she frequently will get it—then you'd better go ahead and get an x-ray, and if it looks like this even here I would be suspicious because you cannot see the aortic arch, you cannot see the bulb

sticking out over the left side so keep in mind that's where the bleeding will occur if there is rupture of the aorta and it's always just distal to the left subclavian. So if there is an enlarging of mediastinal mass, that is in a matter of a couple hours, the patient has a rupture of the aorta maybe completely transected or there may be a little tear in it and that patient may not lose much blood from this but all of a sudden will let go and the patient will die very quickly.

This patient has lost a great deal of blood into his leg and into his pelvis and into various areas. This patient probably does not have a rupture of the aorta but you should keep it in mind because it is a spectacular injury, and it is a correctable injury. It can be corrected right here in this hospital in emergency, and it's a beautiful thing to see and take care of early because it will save the patient's life very frequently. You don't have much time to diagnose it, sometimes, but they may go an hour or so and come to the emergency room with a rupture like this, and then they may deteriorate in the next hour and die, if you do not recognize it.

COL. MONCRIEF: This fellow was getting along pretty well but as they watched him a little more, in spite of what they felt was adequate volume replacement, his pressure went down and his veins started sticking out in his neck and when they listened to his chest, his heart sounds were somewhat muffled. They got an EKG on him and there were some funny changes in this thing. These squiggly lines weren't going the way they were supposed to.

DR. KLASSEN: That's very important. If there's increased venous pressure and the man's suffered an injury of this type, obviously he does not have a tumor, he has increased venous pressure secondary to pericardial bleeding and compression of the ventricles and atrium by collection of blood in the pericardium. In those cases you can quickly determine the presence of blood in the presence of increased venous pressure by putting a needle into the pericardium and getting blood back. And don't worry about it—if the needle goes into the right ventricle you'll get blue blood back—at least you'll know you went through the pericardial space and you did not miss. You did a proper procedure. If you get into the left ventricle you can feel the needle as it hits the muscle of the myocardium. If you get red blood back you're in the left ventricle but you've gone through the pericardial space and if that's negative you get no blood back from the pericardium. You know then that the patient does not have pericardial bleeding—hemorrhage.

COL. MONCRIEF: Well, you've tapped him once and a couple hours later he's back in the same condition again.

DR. KLASSEN: And I did get blood out the first time?

COL. MONCRIEF: You got about 75 ccs of blood out the first time and a couple hours later he's back where he was before you stuck a needle in him.

DR. KLASSEN: I would take him to the operating room and open his chest over the left side and take a look and see because he may have a rupture of his ventricle, a small area, he may have some kind of an injury that's causing bleeding . . .

COL. MONCRIEF: How many times would you do a pericardicentesis before you took him up there to the operating room?

DR. KLASSEN: You know me well enough. I would do it only once and then I would cut.

COL. MONCRIEF: Well, this fellow had his pericardicentesis and he got along fine, he didn't seem to reaccumulate any blood but his heart didn't seem to be working quite right. What has happened to him?

DR. KLASSEN: It's amazing how few patients I've seen with this particular type of injury personally. You probably have seen them. I've seen very few people who had myocardial injury—damage to the myocardium. I'd call a medical colleague probably—cardiologist. I wouldn't do anything about it.

COL. MONCRIEF: You think, then, that this is a medical disease and not a surgical disease?

DR. KLASSEN: I don't think a surgeon could do anything for him. No.

COL. MONCRIEF: He does probably, however, need some sort of support to his myocardium if he's got significant myocardial damage—enough to show up on EKG.

COL. MONCRIEF: Would any of the other members of the panel like to mention something that I may not have brought out here? What they think this patient should have. Yes, Dr. Klassen.

DR. KLASSEN: I have a question. I think these patients should have an upright chest x-ray. Dr. Briggs will agree with me, but the neurosurgeons say you can't do that. You can't sit them up and the orthopedic man says you can't move their broken leg. Now, I insist that they be taken upright then you can see fluid levels and collapse of the lung. How about it, Dr. Coleman?

DR. COLEMAN: The most important thing here is the chest and not the extremities. Usually little damage to fractured extremities will occur with careful positioning for x-rays.

COL. MONCRIEF: How about it, Dr. Barnes? Dr. Klassen says you don't want him moving these patients around to get a chest film on them.

DR. BARNES: I don't really much care where they move the patient as long as they're careful and the patient does not show progressive neurological deficit.

COL. MONCRIEF: What do you mean? How are they going to be sure they're not going to be doing this?

DR. BARNES: You can't be sure he's not going to show progressive deficit. You can only be sure that he *is* or *is not* doing it by following him closely, i.e., by continuous observation of level of consciousness and neurologic condition.

COL. MONCRIEF: How are you going to move this individual physically that will give him the least chance of deteriorating as a result of your manipulations?

DR. BARNES: If you're talking about head injuries, he's not going to deteriorate from manipulation.

COL. MONCRIEF: No, but he's been busted up several places.

DR. BARNES: But if he had any indications of cervical spine injury—and the primary indication of cervical spine injury is, as a matter of fact, a head injury—then great care must be used in moving him. Any force applied to the head has to be transmitted in some way or another to the cervical spine. Therefore, any head injury has to be considered a potential neck injury as well. So he's got to be moved in such a way that his head, his neck, and his thorax are in one position, as a rod. Otherwise, an ordinary, routine cervical fracture may be transformed into a severe contusion or laceration of the cervical cord which would result, not in six weeks of traction and up and at them again, but in a lifetime of quadriplegia which is, at best, terrible.

DR. TAYLOR: Dr. Moncrief, what about this circumferential burn on the arm? I'm surprised that no one's mentioned this.

COL. MONCRIEF: I knew somebody was going to ask me a question about that. The burn wound itself takes last priority in treatment, except for one instance, which is illustrated here. This circumferential burn which is full thickness on this man is the same as if Dr. Coleman had one of his interns put a skintight cast on a fellow with a supracondylar fracture. This has to be split just like Dr. Coleman's cast is going to have to be split when they put it on tight. Otherwise this man can lose his hand as a result of ischemic necrosis. This can be done very simply. It can be done in the emergency room with a scalpel without any topical, local or general anesthesia. Just cut right down through there and bivalve this arm in the area where this burn is located. Then you can forget about his burn and take care of the rest of him. This should be done within the first few hours after he's burned, if there's any indication that he's developing progressive vascular deficit. This is first indicated by a bluish discoloration of the hand and pain in the hand. Not only can he get ischemic necrosis of the hand, but

he can get a permanent nerve deficit in the distal portion of the extremity as well. Are there any questions that members of the audience would like to throw to the panel?

QUESTION: This man has a severe head injury and also a flailed chest. I just wondered who's going to get him first in the operating room, Dr. Barnes, or Dr. Zollinger? And do they or do they not want to operate together when they get him up there?

COL. MONCRIEF: Dr. Zollinger, you're going to be the head man on this—I mean that figuratively, Dr. Barnes—well he might let you get your hand in the belly, you see. What are you going to do here? The man's got a flailed chest, he's got a ruptured spleen, he's got an epidural hematoma.

DR. ZOLLINGER: Well, they said he had a tube in his chest. I assume the tube in his chest is to control any pneumothorax. Obviously, he has a flail chest. With a tube in his chest, the flail chest won't be too much of a problem anyway because this can be controlled by the anesthetist at the time of surgery with positive pressure anesthesia. At the time of surgery I'd say it would be a tie between Dr. Barnes and me, and I suppose we'll both go to work at the same time, if room can be made at the operating table.

COL. MONCRIEF: Actually, if you've got him in the operating room and the anesthesiologist has an endotracheal tube in him he's probably as well off there as he is anywhere as far as his air exchange is concerned. Once he gets up there he shouldn't have any problem from that standpoint. There wouldn't be any great problem, really, in opening up his belly and his head at the same time. As Dr. Zollinger is saying—he doesn't want to fight too hard with Dr. Barnes as to who gets him first. If he's getting a progressive neurological deficit and if he's progressively dropping his pressure that he can't maintain—this may be all due to his head injury. It doesn't necessarily have to be due to volume deficit plus a head injury. It would be a hard thing to decide. Dr. Barnes—

DR. BARNES: I believe that, if the blood pressure can be maintained at an adequate level, the epidural should be removed, posthaste. I don't mean that the entire procedure of craniectomy and ligation of the vessels need be done, only evacuation of the mass. You can replace his blood volume, but you can't replace the brain tissue that's going to be damaged by the enlarging mass. All I want to do is make an opening in the skull. Then I'll let him bleed if need be and permit the other critical injuries to be repaired, and then stop the intracranial bleeding.

COL. MONCRIEF: Another question in the back?

QUESTION: Should this man have an IVP done?

COL. MONCRIEF: Dr. Rehm, what do you think

about an I.V. pyelogram in this individual for part of his initial evaluation?

DR. REHM: It's of absolutely no value; he's in shock and the pyelograms will not visualize. It won't give you any information about his renal function whatsoever.

COL. MONCRIEF: Suppose he's not putting out any urine?

DR. REHM: This will be because of hypotension not renal injury.

COL. MONCRIEF: Suppose you get him out of shock and he still isn't putting out any urine?

DR. REHM: The problem of anuria after he's stabilized should suggest a blood reaction.

COL. MONCRIEF: You think, then, that you have satisfactorily determined he doesn't have any urinary tract obstruction that's causing his anuria, that makes you think he might have acute tubular necrosis?

DR. REHM: This diagnosis is sometimes difficult because retroperitoneal hematoma may obstruct both ureters. The urologist may at some time want to do retrogrades if there is a strong question of urinary obstruction.

COL. MONCRIEF: Dr. Taylor.

DR. TAYLOR: Do you want to say a few words about tetanus prophylaxis in this man?

COL. MONCRIEF: I think Dr. Furste's movie the gentlemen saw before we came in here pretty well covered that. I think it would be difficult to be certain of this fellow's ability to communicate, if you will, exactly what was his immunological history. He's a young fellow and it doesn't look like he's probably been in the service yet, therefore he may not have been immunized. I think to be on the safe side—although there are new tests available to tell whether or not he has an adequate protective antibody level and these are not in widespread use—it would probably be the safest thing to give him hyperimmune gamma globulin. You can give him his booster dose or his initial immunization at the same time. I don't think one should waste time in trying to get a definitive history out of this fellow that isn't going to give you a straight answer. I don't know whether his wife is around anywhere to give you one or not. She may know his history and she may not. To be on the safe side he should be covered.

RADIOLOGIST: I think there's one other dilemma here concerning this upright chest film concerning whether or not you should send this type of patient to the x-ray department. I think that the ideal situation would be that the emergency facility take x-rays and to be very selective to see what the femur's going to show maybe what the bladder and pelvis is going to show. The chest is most important.

COL. MONCRIEF: What about bringing the x-ray to the patient?

RADIOLOGIST: This is what should be done. If the patient is not stable he certainly should not be sent to the x-ray department to be manipulated by a nonprofessional person in any way.

COL. MONCRIEF: How about using a portable machine if you've got it?

RADIOLOGIST: Yes. And preferably a rapid processing system, so we don't have to wait 10 or 20 minutes to get the results back.

QUESTIONER: Someone on the panel mentioned a central venous catheter in this fellow on admission. I think that would have been very helpful. Would someone on the panel comment on the utilization of antibiotics?

COL. MONCRIEF: Dr. Zollinger, would you give this fellow antibiotics and, if so, what would you give him and how would you give it?

DR. ZOLLINGER: Obviously you can't give him oral antibiotics so I would place penicillin in the intravenous solutions, perhaps give it intramuscularly after he is out of shock and then give it orally if necessary after he is able to handle it orally.

COL. MONCRIEF: There was a question of whether or not you would put in a central venous pressure catheter—

DR. ZOLLINGER: I think you'll be busy enough caring for this man without worrying about a central venous pressure catheter, though if we have plenty of help and it can be done easily, I see nothing wrong with placing a long catheter into the antecubital veins and recording venous pressure periodically. From a more practical standpoint, however, this patient is obviously in shock and we know he has lost 20 per cent of his blood volume. We can estimate roughly that his circulating volume would probably be 7 per cent of his weight in kilograms and 20 per cent of this total would be a rough estimate of what we need in the way of blood replacement to start with so we know in this man's case that we are going to have to have a liter of blood plasma expander of some type to start immediately until blood is available.

COL. MONCRIEF: Suppose you're very fortunate and you've got a lot of people around there that want to study this fellow and you measure the blood volume on him and you predict that he's going to have 5600 milliliters of blood as a normal blood volume and your report comes back 5800 milliliters and he still doesn't look good. How do you reconcile the fact that he's got a normal blood volume when you measured it but he doesn't look good? Excluding his head injuries.

DR. ZOLLINGER: But he's still got a normal blood volume?

DR. MONCRIEF: As measured by your isotope technique—yes.

DR. ZOLLINGER: I don't know about using radioisotope techniques at the time of shock. I don't think this is a very practical thing. I don't think it's proven to be worthwhile. If you're asking me to explain this blood volume picture here I can't.

COL. MONCRIEF: The point I was trying to bring out is that we're not interested in this patient's anatomical blood volume—how many milliliters of blood he has—but how he's using the milliliters of blood he has. In other words what is his functional blood volume? Is his heart able to pump around what he's got and is what he's got normal for the condition he's in? He may have a lot of peripheral or visceral vasodilatation and, just because you measure this volume, it doesn't mean that it's a normal functional blood volume. In fact, many of these individuals will require as much as 50 per cent more anatomical blood volume to have a normal functional blood volume. So a lot of times you have to over-transfuse, overhydrate these individuals in order for them to respond normally to the massive trauma that they've had. Dr. Zollinger mentioned the expansion of his extracellular space. One of the problems this fellow has with his femoral fracture, excluding vascular and nerve damage and the bone itself, is the fact that he can sequester six to eight liters of extracellular fluid in this thigh as a result of the massive soft tissue injury, not only extracellular fluid but blood. He can get a tremendously large hematoma in these thigh muscles, even if he doesn't lose blood in his pelvic fracture and his ruptured spleen and everything else. These things have to be considered. So salt water, as Dr. Zollinger mentioned, is extremely important in the resuscitation of these individuals along with whole blood or some other type of colloid volume expander. I think Dr. Zollinger's quite correct in saying that you've got a lot of other things to do and to put a central venous catheter in here is real nice to study patients, but for the individual patient you're trying to take care of, it's not going to do a whole lot that good clinical observation and his response to therapy doesn't tell you just as well and probably a whole lot faster.

QUESTIONER: Dr. Barnes, is there some way you can establish whether this fellow has a broken neck or not before you start manipulating him?

DR. BARNES: If you could elicit clinical signs or symptoms of cord injury you could establish the fact that he has cord damage.

COL. MONCRIEF: Suppose he doesn't have any neurological signs?

DR. BARNES: The other indications of cervical spine injury with or without concomitant cervical cord injury are deformity of the cervical spine and pain or tenderness in the area. But *most* important is that *the patient with a head injury has a cervical spine injury until it's proven otherwise.*

Traumatic Pancreatitis and Retroperitoneal Rupture Of the Duodenum

A Complication of Steering Wheel Injury

ROBERT L. HAUMAN, M. D.

TRAUMATIC pancreatitis and retroperitoneal rupture of the duodenum are infrequent complications of blunt abdominal trauma. Of 700 cases of injury to the pancreatic-duodenal area collected from the literature, 124 were due to blunt trauma.¹⁻⁴ A review of the records of patients hospitalized in the Toledo area for blunt abdominal trauma was carried out to determine the frequency of this type of injury and to assess the factors contributing to the high mortality.

Clinical Material

One thousand cases of blunt abdominal trauma were reviewed from St. Charles, Riverside, St. Vincent and Maumee Valley Hospitals of Toledo, Ohio, from 1958 to 1963. Twenty-five patients with either traumatic pancreatitis or retroperitoneal rupture of the duodenum were found. There were 18 patients with both lesions, 3 patients with traumatic pancreatitis alone and 4 patients with isolated retroperitoneal rupture of the duodenum. The diagnosis was confirmed by operation or autopsy in all patients.

In all but four instances the steering wheel was the instrument by which the force was transmitted to the upper abdomen. The dashboard was presumed to be the traumatic agent in one case. Two cases occurred in children struck by an automobile, and one case occurred in a child who fell against the handle bar of a bicycle. In other series, beatings, falls and crushing injuries have been implicated.

Mechanism of Injury

Following impact to the right upper quadrant, the liver, protected by the rib cage, is displaced upward and the hepatic flexure of the colon is pushed inferiorly. Since the head and body of the pancreas and the second portion of duodenum are fixed to the posterior abdominal wall, a sheering force is exerted in the plane of the common bile duct, the gastroduodenal artery and the transverse mesocolon. Force directly over the pancreas results in contusion and fragmentation.⁵ The retroperitoneal duodenum closed proximally by the pylorus and distally by the

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acute angulation at the ligament of Trietz, is disrupted by the extrinsic pressure acting on a closed loop.

Diagnostic Considerations

Early diagnosis of retroperitoneal rupture of the duodenum and traumatic pancreatitis, occurring together or separately, is imperative. A delay of 24 hours or more is associated with a mortality approaching 100 per cent. In this series, the diagnosis was entertained on admission in less than 30 of the 1,000 patients with multiple injuries and in only 10 of the 25 who actually had the lesion. Thus, the most important factor in the diagnosis is an awareness on the part of the examiner that it may be present in any patient who has sustained blunt abdominal trauma.

The most consistent presenting sign is abdominal tenderness accompanied by ileus and mild peritoneal irritation. Abdominal pain is usually present, but there is no typical pattern of localization. The time of onset of the pain varies considerably. Nausea, vomiting, hematemesis, and the physical signs of peritonitis eventually occur in all cases. Their appearance often indicates a delay in diagnosis and a grave prognosis.

Eight of our patients presented with tachycardia, mild hypotension, restlessness, and diaphoresis. In five patients these findings were attributed to either head injuries or extremity fractures. A four-quadrant peritoneal tap was utilized in eight cases, three of whom had clinical evidence of peritonitis at the time of examination. Bloody or turbid fluid was obtained in five.

Serum amylase determination may be of help in arriving at a tentative preoperative diagnosis. They were not carried out routinely in this series. The

values that were measured were elevated in varying degrees. Six of the eight patients had clinical signs and symptoms of advanced peritonitis at the time of measurement.

Retroperitoneal air was noted on three abdominal plane films, and was instrumental in establishing the diagnosis.⁶ Psoas shadows were obliterated in seven cases. However, this was either a delayed finding accompanied by clinical evidence of frank peritonitis or, if early, occurred with other intra-abdominal abnormalities.

Treatment

Immediate operative intervention has been established as the only reliable approach to this problem.

In this series, five patients were treated conservatively because of errors in diagnosis or a delay in diagnosis so that heroic attempts at reconstitution were mandatory prior to operation. The results were catastrophic. Two patients with traumatic pancreatitis alone survived but developed pseudocysts. Surgical drainage was achieved in one instance, and in the other, death resulted from exsanguinating hemorrhage three weeks post-injury and prior to definitive surgery. The other three patients died with peritonitis and overwhelming sepsis.

The diagnosis was overlooked in three patients who subsequently died following exploratory laparotomy for other intra-abdominal injuries. A most important observation on surgical management is illustrated by three tragic examples. These patients had surgery (two for lacerations of the liver, one for rupture of the spleen). Certainly laparotomy in the seriously ill patient must be carried out speedily and with precision, but without compromising a thorough assessment of the abdomen. Adequate inspection of the pancreas can be best achieved by opening the lesser omental sac widely. Bile staining, minor degrees of edema, and the presence of blood within the stomach should direct attention to the posterior surface of the duodenum and to the pancreas.

Specific operative management of the damaged pancreas will depend upon the type of injury. Definitive surgery should be limited to evacuation of hematomas, control of hemorrhage, and adequate drainage.^{7,8} The most effective operative measure is the institution of adequate drainage.⁹ Leakage of pancreatic juice into the peritoneal and retroperitoneal spaces is an inevitable accompaniment of maceration and destruction of pancreatic tissue. Contamination, contusion, and pancreatitis compound the natural healing deficiencies of the retroperitoneal duodenum. In this series, lack of drainage was associated with a 100 per cent mortality.

The complications of abscess formation, duodenal fistula, bile peritonitis, and secondary hemorrhage have led to more aggressive measures than simple drainage. Doubilet and Mulholland advocate sphincterotomy and catheter drainage of the pancreatic

duct.¹⁰ Hannon and Sprafka and Blandy have utilized extensive resection.^{11,12} Letton and Wilson treated transection of the pancreas by closing the distal side of the head, using a Roux-en-Y loop of jejunum to drain the distal neck.¹³

The duodenal injury is usually linear and, in most cases, repair can be achieved by simple closure. Circumferential tears may require the adoption of a wide variety of surgical techniques. Lacerations at or near the ampulla of Vater are a very difficult problem. When the anatomy is distorted by hematoma and edema, primary repair may be impossible without transposition of both the common bile duct and the pancreatic duct.

Complications

Multiple injury, hematoma, devitalized tissue, and perforation of the bowel make infection the most common complication. Debridement, hemostasis, and drainage attempt to limit this process.

Pneumonia and atelectasis were the second most common complications. Peritonitis, sepsis, and associated blunt chest injury contributed to the atelectasis and pneumonitis.

Pseudocyst formation can occur, and it is this complication which has prompted many surgeons to adopt initial reconstructive procedures on the pancreatic ductal system. Adequate drainage is imperative. In this series, both patients who did not have drains inserted developed pseudocysts with isolated pancreatic injury. Two pseudocysts developed when drainage procedures were used for treatment of the combined lesion. Drainage into a defunctionalized loop was the method of secondary management in three cases.

The fourth patient deserves further comment. This woman was treated conservatively for three episodes of massive upper gastrointestinal hemorrhage, requiring as many as five units of blood on each occasion. After a protracted hospital course, she was discharged only to die two weeks later from an exsanguinating hemorrhage. Autopsy revealed pancreatic necrosis and pseudocyst formation associated with a severe gastritis but without evidence of gastric or duodenal ulcer. Massive gastrointestinal hemorrhage without evidence of ulcer formation was the third most common complication of traumatic pancreatitis in the recent report of Cleveland.² The aforementioned case adds further support to the hypothesis that pancreatic inflammation may underlie gastric hemorrhage from lesions other than ulcer.

Fistula formation also may occur as a complication. In this series fistulas resulted from one case of traumatic pancreatitis, two cases of retroperitoneal rupture of the duodenum, and four cases where both lesions occurred. The fistula associated with isolated traumatic pancreatitis closed spontaneously as did the

fistulas in association with isolated duodenal injury. Two of the fistulas, occurring with the combined lesion required further definitive surgery. The other two patients have been lost to follow-up.

Mortality

The mortality figures for the isolated injuries were 50 per cent for retroperitoneal rupture of the duodenum and 66 per cent for traumatic pancreatitis. This is much higher than is generally reported.

The combined lesion is a very lethal one. This report details 12 cases out of 18 or approximately 66 per cent. In the majority of cases there were associated injuries to other abdominal viscera or extremity fractures.

Summary and Conclusions

Twenty-five cases of retroperitoneal rupture of the duodenum and traumatic pancreatitis have been found in 1,000 cases of blunt abdominal trauma treated in the Toledo area from 1958 to 1963, suggesting that this lesion occurs more frequently than is generally reported. The majority of the injuries were caused by blows inflicted by the steering wheel. Seventeen patients died. In spite of the fact that many had associated injuries which undoubtedly contributed to their death, a mortality figure of 68 per cent is unacceptable. Eight patients died with the diagnosis unsuspected, five patients were operated upon after a

delay in diagnosis of more than 24 hours, and three of these were not adequately drained.

A plea is made for the more frequent consideration of this diagnosis in patients sustaining blunt abdominal trauma. The seriousness of the injury demands early diagnosis and immediate operative intervention.

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LUPUS ERYTHEMATOSUS.—The clinical analysis of 154 patients with abnormal L.E.-cell preparations and 124 randomly selected patients with negative tests is presented. Typical L.E. cells constituted the initial abnormality in 60 patients whereas homogeneous extracellular material (ECM), histologically identical to the L.E.-cell inclusion body, was the initial finding in 94.

ECM was less specific than the L.E. cell for the diagnosis of systemic lupus erythematosus, with 24 per cent of the ECM-positive patients satisfying our criteria for definite or possible systemic lupus erythematosus as compared to 60 per cent of those with L.E. cells. When compared to those having negative tests, however, those with ECM have a higher frequency of those disorders with which the L.E. cell has been associated.

L.E. cells were associated more closely with the clinical syndrome of systemic lupus erythematosus than any other but were also found in patients who did not satisfy our criteria for systemic lupus erythematosus. Thus, L.E.-cell positivity should be considered only one of the *major* criteria for diagnosis.

The appearance of an abnormal L.E.-cell test in patients with rheumatoid arthritis and discoid lupus does not correlate well with the degree of multi-system involvement.—Mary B. Stevens, M.D., Helen Abbey, Sc.D., and Lawrence E. Shulman, M.D., Baltimore, Md.: *The New England Journal of Medicine*, 268:976-982, May 2, 1963.

Maternal Deaths Involving Paralytic Ileus*

By the OSMA COMMITTEE ON MATERNAL HEALTH

With Comment of Consulting Obstetrician and Gynecologist

ADYNAMIC, or paralytic ileus associated with pregnancy or the puerperium is an extremely uncommon, but devastating complication. Usually, it appears following an abdominal operation, principally cesarean section. The Committee on Maternal Health reported only three maternal deaths (.0387 per cent) of the 779, covering a 10 year Survey¹ of Ohio Maternal Deaths, 1955 to 1964, due to paralytic ileus.

Herewith, the Committee presents the three cases; all three patients died following a primary cesarean operation, two of which followed long, unsuccessful labor. The third patient submitted to surgery after an accidental rupture of the amnion and prolapse of the umbilical cord.

Case No. 121

A 39 year old, colored, abortus I, cesarean I, died eight days postoperative (cesarean section). Her past history was noncontributory. She had a previous pregnancy which terminated in the 12th week as a "spontaneous miscarriage," without curettement. The details are not known. With her last menstrual period March 22, she registered with her physician and made 15 prenatal visits. According to the record there were no complications; heart, lungs and pelvis were reported normal. The VDRL was negative; blood was Rh positive. Weight gain and other details of the pregnancy were not known; prenatal care was considered adequate. Past term, the patient's membranes ruptured and she entered the hospital January 9 (42 weeks gestation) in early labor, at 1:30 A.M.

Details of the patient's progress the next few days were not available; however, x-ray of her pelvis was reported "adequate." Labor "progressed poorly" for over 29 hours; the presenting head did not descend nor did the cervix dilate. Medication included Nisentil®, Tuinal® and hyoscine given for analgesia. Four or five rectal examinations were performed by residents and a consultant. On January 10 a low cervical cesarean operation was performed under spinal anesthesia, administered by a physician, and a live baby weighing 7 lbs. 7½ oz. was delivered. Blood loss was not mentioned.

Vital signs and other details of the postoperative course were not recorded, however, the second day 1 unit of

whole blood was given because of "mild shock"; also a cardiac arrhythmia developed. The fourth day abdominal distension indicated the beginning of a paralytic ileus which became progressively worse, in spite of "every adequate medical and nursing effort." Laboratory tests are said to have indicated signs of a moderate uremia. The ileus persisted, the patient pursued a downhill clinical course and died January 18. An autopsy was permitted but the report was not available.

Cause of Death (Autopsy): Paralytic ileus; Poss. ventricular fibrillation; (not mentioned, uremia).

Comment

Members of the Committee pondered over the available information in this case noting that certain pertinent facts were not reported. It was felt that sepsis (perhaps peritonitis) was present postoperatively, and the possibility of septic shock was projected "between the lines." It was not clear why the patient was allowed in labor 29 hours, without progress, before intervention; no vaginal examination was reported to confirm findings on rectal examinations. A question was raised concerning results of physical examination of the patient (e.g., heart, etc.) during the several days after her admission; likewise, urinalysis and hemogram studies. By a rather narrow margin, this case was voted a *nonpreventable* maternal death.

Case No. 321

This patient was a 26 year old, white, Para III, cesarean I, who died 10 days postcesarean section. Her past history revealed a severe attack of bulbar poliomyelitis at age 18; there was a residual complete bilateral paralysis of the lower extremities, and one upper arm, with weakness of chest and abdominal muscles and general debility. She had had two previous term pregnancies without complication, both vaginal deliveries. Prenatal care during the third pregnancy was considered adequate, with eight visits.

No complications developed until 2:00 P.M., September 26 (40 weeks gestation) when the amnion ruptured spontaneously, and the fetal umbilical cord prolapsed. There was no labor. Promptly, she went to the hospital where an emergency cesarean section was performed under the spinal anesthesia (7.0 mg. Pontocaine® in 10 per cent dextrose). A living 6 lb. 12 oz. baby was delivered at 6:10 P.M.; other details of the operation are not recorded.

Following surgery the patient was returned to her room in good condition, vital signs normal; she was started on

*A continuous state-wide Maternal Mortality Study is being conducted in Ohio by the Committee on Maternal Health of the Ohio State Medical Association, in cooperation with the Ohio Department of Health and representatives of the various County Medical Societies. Summaries of some of the cases studied by the Committee, based on anonymous data submitted, are published here from time to time, interspersed with statistical summaries.

a course of Ilotycin®, since she was unable to take penicillin. On the first postoperative day she received a liquid diet; her temperature was 99.2° and the urinary output satisfactory. The next day she developed nausea and (brown liquid) emesis with 99.2° temperature; each day she was allowed to be up in a chair. The third postoperative day nausea and emesis were less; a rectal tube and Prostigmin® were ordered.

Abdominal distension appeared on the fourth day; liquids, soft food and Prostigmin were continued. A rectal tube was utilized. Parenteral fluids were given on the fifth day, after a Levin tube was inserted. The temperature was recorded as normal. Progress was unchanged; on the seventh day an enema was fairly effective. The next day after removal of the nasal tube, a liquid diet was prescribed. Abdominal distension remained; the patient's extremities were mottled and cold. The ninth day was reported to be "good" with normal temperature and blood pressure. On the following day distension persisted, the patient vomited and a Levin tube was reinserted; she died at 11:20 P.M. There was no autopsy.

Cause of Death (Certificate): Paralytic ileus, postoperative 10 days; general debility and paralysis, postbulbar poliomyelitis; status postcesarean section, delivery of living baby.

Comment

The Committee voted this case a nonpreventable maternal death after a considerable discussion. Members regretted the lack of some pertinent details not available from the records, and raised several questions devoid of an answer: (a) why was a spinal anesthesia selected for a patient with residual paralytic defects following poliomyelitis; (b) was there a reason for waiting several days to commence gastric suction (the tube); (c) what attempts were made to ascertain and correct electrolyte imbalance; (d) several members wondered if the proper facilities were available to *perform* the cesarean section.

Case No. 670

A 37 year old, white, Para III, cesarean I, who died six days postoperative (cesarean). This patient's past history was not recorded; she had had three term pregnancies, all vaginal deliveries. In her fourth month she registered with her physician and made eight prenatal visits. The VDRL was negative; blood type, Rh factor and hemogram were not known. Outside of one blood pressure reported to be 142/80 (August 1) there were no complications of pregnancy. On August 7, at term the patient began labor spontaneously. She was admitted to the hospital at 3:05 P.M. in active labor, membranes ruptured. Records do not reveal the type of medication she received. After 12 hours of labor and a number of rectal and vaginal examinations (?) uterine inertia developed. X-ray studies revealed a flat sacrum and occiput transverse position of the fetal head. Consultation was obtained. "Early signs of toxemia" (?) had developed gradually.

On August 8, after further consultation, a classical cesarean section was performed under nitrous oxide and cyclopropane anesthesia (50 minutes) administered by a physician. A living 8 lb. 9 oz. baby was delivered in good condition. The operation was said to be uneventful (details not recorded). When the patient developed abdominal distension on or about August 11, gastric suction was started; electrolyte balance was maintained. But the patient objected seriously to the "nasal" suction tube, removed it, became disgruntled and failed to cooperate in any manner. The blood urea nitrogen rose, she developed (clinical) uremia, and died in spite of therapy on August 14. "Adynamia" was thought to be associated with (possible) mesenteric infarction. There was no autopsy.

Cause of Death (Certificate): Adynamic Ileus; uremia; embolic mesenteric infarction.

Comment

With considerable interest, members of the Committee reviewed this case, regretting that many pertinent details were lacking in the record, e.g., (1) The station of the fetal head and condition of the cervix, on admission and at various intervals during labor, as well as progress revealed after 12 hours of labor. (2) Was any medication administered during labor? (3) What were the findings indicating toxemia? (4) Was the toxemia treated? (5) Why was a classical cesarean section done in preference to a "low flap" type? (6) What early antibiotic medication (if any) was administered postoperatively, in view of potential infection? Much was made of the patient's uncooperative status; but members suspected that the patient was too ill to be cooperative. It seemed a Cantor or Miller-Abbott tube might have been useful; also some cholinergic drug given early, might have reduced the ileus. After prolonged deliberation, the Committee voted this a preventable maternal death.

Comment of Consultant

The following comment of a consultant, who is a specialist in Obstetrics and Gynecology, was furnished at the request of the Committee.

"These three patients died from peritonitis following cesarean section. They did *not* die of paralytic ileus. It is unfortunate that pertinent details were missing from the (available) records making it impossible to pinpoint the exact cause of fatal peritonitis in these patients.

"Paralytic ileus or adynamic ileus is *not* a disease. As a signal, it is merely a physiologic response to peritoneal insult. It does occur in peritonitis; it can also occur in the absence of peritonitis when a patient swallows large amounts of air in the act of deglutition after major abdominal surgery. In this condition, peristalsis diminishes, or ceases. Its presence can be confirmed clinically by auscultation of the abdomen. This absence of peristalsis has been explained as nature's defense against intestines 'swishing about' in the presence of a leaking viscus. It is also nature's defense against localized infection becoming a generalized peritonitis. Peristalsis is normally accompanied by hunger, and a sense of well-being. It is trumpeted by the passage of flatus.

"Paralytic ileus is *not* synonymous with 'abdominal distension.' Board-like rigidity of the abdomen prevents abdominal distension immediately following the perforation of a peptic ulcer, although the abdomen is 'quiet' and the ileus is profound. On the other hand, marked distension is seen in patients with the classical hyperactive, mechanical bowel obstruction.

"The Committee, in respective 'comment' on each case, has portrayed most of the pertinent and illuminating problems developed in each patient. However, this consultant desires to point out several items:

"Case No. 121 reveals that the patient developed 'shock' (without mention of fever) followed by 'ure-

mia', beginning on the second postoperative day. Probably, this was endotoxic shock, treated with the administration of a unit of whole blood, only.

"In *Case No. 321* was the dosage of Ilotycin enough? And I note that the patient was given a 'liquid diet' the *first* postoperative day, continued through the fourth day, in the face of 'distension.' Personally, I allow these patients to have 'tap water' only for the first 24 to 36 hours postoperative, advancing to liquids and soft diet *after* the normal recovery course is insured. The Committee's comments are extremely pertinent!

"*Case No. 670* brings up the rationale and indication for the cesarean section. From the information available, one can only speculate as to the cause of the 'uterine inertia'; there is no clue concerning the station of the presenting part, nor the condition of the cervix. After a brief rest afforded by proper medication, labor might have resumed to provide a vaginal delivery. And again, why was the *classical*

type of cesarean section chosen? Likewise, there is insufficient information available to make a diagnosis of toxemia, or a clinical basis for the uremia.

"In summary, it is impossible to state whether or not these three patients received adequate treatment for peritonitis. It must be remembered that patients still die from sepsis, despite the best consultation and therapy available. To prevent and overcome paralytic ileus, vigorous and prompt efforts to pinpoint the cause of peritonitis still remain the *most* important weapon! Only after this important initial problem is solved, can the acutely ill postoperative (cesarean section) patient be treated effectively. The next normal step consists in the administration of massive doses of antibiotics, specifically tailored to meet the sensitivity of the microorganisms recovered from the site of the infection."

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HEREDITY AND ENDOMETRIAL CARCINOMA. — A study of medical records of 154 probands with histologically verified endometrial carcinoma has shown a striking association of obesity, diabetes mellitus and hypertension. Endometrial carcinoma occurred in 16 per cent of probands' first degree relatives. These data, when compared with the occurrence of endometrial cancer in so-called "cancer families," suggest the possibility of two genotypes for this lesion: (1) *site specific* in some kindreds; (2) occurrence of endometrial carcinoma as the most frequent lesion in families with a high frequency of cancer of *all sites*. However, modes of inheritance are not clear in the two settings. It is suggested that the specific lesion may be caused by an inherited endocrinologic defect, giving rise to obesity, hypertension, diabetes mellitus, dysfunctional uterine bleeding, endometrial hyperplasia, endometrial polyps, leiomyoma uteri, and other constitutional factors.

It is further suggested that endometrial carcinoma be considered in the context of a phenotype with a cancer diathesis in the same sense as other hereditary disorders, i.e., Gardner's syndrome, Peutz-Jeghers syndrome, neurofibromatosis, and the nevoid basal cell carcinoma syndrome. — Henry T. Lynch, M. D., Anne J. Krush, M. S., and Arthur L. Larsen, M. D., Houston, Texas: *Southern Medical Journal*, 60:231-235, March 1967.

A Baedeker for Fat-Controlled Diets

V. Basic Foods

HELEN B. BROWN, Ph.D.,* and MARILYN FARRAND, M.S.†

ASK A MAN what he had for dinner and he will mention the meat course. Meat is a favorite food and determines the character of the entire meal, making it varied, interesting and enjoyable. Unfortunately the fat in food products of animal origin—meat, poultry, eggs, dairy foods—is high in saturated fatty acids, which raise blood cholesterol levels.⁵ Fat from fish is an exception. Both animal fat and animal tissue, including fish, contain cholesterol, which is also hypercholesteremic. Most of these foods may be used in fat-controlled diets by proper selection and preparation to reduce fat content. In other words, they become low-fat products. Meats, like bacon, in which fat cannot be reduced substantially, are not used.

Meat selection is crucial in achieving effective fat-controlled diets.⁴ Animal fat should not exceed 15 grams a day—the amount in 6 ounces or two servings cooked lean meat or poultry. Beef, lamb, pork and ham with the least amount of marbling (a mixture of fat with lean) are included. Cuts from the hind-quarter and loin are leanest. Most cuts of veal and poultry, not including skin, are low in fat. Because of its low amount of saturates, fat from fish is limited only in low-fat diets.

To make selection easy, meats are listed below according to fat content of three ounce cooked edible portions,⁶ unless indicated otherwise. By choosing one serving from the low-fat group and one from the medium-fat, 15 grams of meat fat is obtained. Other combinations are possible, depending upon one's preference.

Low-fat group (5 grams fat):

White meat of poultry, veal cutlet, seafood, liver, heart.

Medium-fat group (10 grams fat):

Beef—chipped, smoked, shank; steaks (round, flank, tenderloin, sirloin); roasts (sirloin tip, standing rump), tongue.

Veal, all other cuts. Lamb (leg, loin chops). Dark meat of poultry. Canadian bacon. One frankfurter. One ounce luncheon meat.

Medium high-fat group (15 grams fat):

Beef—chuck, lean stew, lean hamburger; steak (T-bone, porterhouse). Ham. Pork loin.

The size of meat portions may be judged by knowing dimensions of some common 3-ounce cooked servings: 2 slices roast beef, 4 by 2 by 1/4 inch; beef patty, 3 inches in diameter and 1/2 inch thick; 1/2 breast, or leg and thigh of a 2 1/2 to 3-pound chicken. A 5-ounce raw chop with bone will have 3 ounces lean meat when cooked. Meat shrinks one fourth during cooking, so that 4 ounces raw meat yields 3 ounces cooked.

Other animal products may be *substituted* for meat, such as liver, shellfish, eggs, and even cheese and ice cream. Because liver and shellfish contain more cholesterol than meat, they should be eaten only occasionally; up to four eggs a week may be used, depending on the type of fat-controlled diet. Cheese and ice cream must be substituted carefully, since 1 ounce of cheese, the usual package slice, or 2/3 cup ice cream contains 10 grams animal fat, two-thirds the daily allowance.

During preparation, trimming meat removes much of the fat; more fat is removed by broiling, roasting or stewing. The remaining fat should be trimmed at the table. Drippings should be chilled before use, so that fat can be skimmed off easily.

Favorite foods will be eaten occasionally by the most conscientious patient; he might as well choose them intelligently. Admonitions never to eat cheese or eggs or pork are obviously wrong when applied to fat-controlled diets. Most animal products may be used within diet limitations. By so doing, variety

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is increased, adherence improved, and the list of "don'ts" minimized.

In contrast to meat, dairy products can be made practically free of fat. As such, they are used freely in fat-controlled diets and are important ingredients in a variety of dishes. Skim milk is useful as a beverage and in food preparation. It is available fresh, as nonfat dry milk solids or evaporated skim milk. Fresh skim milk is often fortified with nonfat milk solids to improve flavor and appearance. Low-fat chocolate syrup may be added. Uncreamed or dry cottage cheese may be softened with skim milk and flavored with spices, pickles, chopped vegetables or fruits for variety; it may be blended with skim milk to make a "cream" cheese, a dip or even used as a basic ingredient for cheese cake. Most sherbets are made from skim milk.

Besides the low-fat dairy products, there is a large group of foods which have little or no fat. Included

in this group are all fruits and vegetables (except avocados and olives), cereals, simple breads, and sugar. These low-fat foods may be used as desired; they balance the meals and satisfy the appetite.

Food products which have been discussed in this article form the basis of all fat-controlled diets: meats reduced in fat content, low-fat dairy products, fruits, vegetables, cereals, and sugars. The low-fat diet consists of them entirely. The vegetable-oil food pattern includes all these foods plus vegetable oils, which will be discussed in the next Heart Page. How to choose other processed foods will also be considered.

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EPIDEMIOLOGY OF HUMAN LEUKEMIA. — Review of recent epidemiologic studies into the origin of human leukemia revealed the following: (1) Mortality statistics have for the first time shown a downturn in leukemia rates for all ages from 1 through 74 years among the U.S. white population, but not among the U.S. nonwhite population or in England. The possibility that this decline resulted from decreasing exposure to x-rays in medical practice was not supported by an analysis of the limited mortality data available on cytologic types which should be unequally affected by radiation.

(2) Recent leukemia mortality rates for Japanese and U.S. nonwhite children suggest the emergence of an age peak at 3-4 years similar to that previously found among the U.S. white population and in England.

(3) Little evidence was found to support the hypothesis that aggregates of childhood leukemia or patient-pet clusters represent foci of infection. Despite recent searches for other infectious patterns in the distribution of human leukemia, the observation most suggestive of a viral influence is the geographic distribution reported for Burkitt's lymphoma in Africa.

(4) Recent observations have extended knowledge of groups who are born with or who acquire, from ionizing radiation or chemicals, a high risk of leukemia. Compilation of case reports of certain genetic diseases suggested that the heritable disorders associated with cytogenetic defects predispose to leukemia, whereas disorders with immunologic deficiencies are related to the lymphomas.

There was a consistency among these observations which supports the notion that the pre-existing abnormalities have pathogenic significance, rather than being concomitants of the neoplastic process. Further study of high-risk groups should significantly enhance opportunities for recognition of etiologic agents and mechanisms in leukemogenesis. ABSTRACT, Joseph F. Fraumeni, Jr., M.D., and Robert W. Miller, M.D.: *Journal of the National Cancer Institute*, 38:593-605 (April) 1967.

A Clinicopathological Conference

From The Ohio State University Hospital, Columbus, Ohio

Edited Under the Auspices of the Ohio Society of Pathologists

PAUL N. JOLLY, M. D., *President*

PRESENTATION OF CASE

THIS 51 year old white male machine operator was admitted to University Hospital, confused and obtunded. One year prior to admission the patient noted the insidious onset of fatigue and increasing pallor. Six months later he experienced episodes of epigastric pain diagnosed as "peptic ulcer." Four months prior to admission he was told that no pulses were palpable in his upper extremities nor could a blood pressure reading be obtained. Two months prior to admission the patient apparently experienced a "stroke" manifested by sudden loss of his ability to speak. He noted some improvement in this during the next several weeks. He then developed an acute surgical abdomen; appendicitis was diagnosed and he underwent appendectomy.

Postoperatively, the patient again could not speak, became markedly confused, and noted weakness of the left hand. Again he noted gradual improvement. Two weeks prior to admission he noted the onset of pain in legs and back and became increasingly confused, obtunded, and unable to speak. Vomiting and constipation developed, and he was admitted to his local hospital. A blood count there revealed a hemoglobin of 8 Gm./100 ml. and a leukocyte count of 10,000 with a normal differential count. The urine contained 75 mg. of protein per 100 ml. and 30 to 40 white blood cells per high power field. Urine cultures grew *Proteus mirabilis*. The total protein of his blood serum was 6.3 Gm./100 ml. (albumin 2.0 Gm., globulin 4.3 Gm.). Bone marrow examination revealed 15 per cent typical plasma cells with some immature forms. He was referred to University Hospital for further evaluation and therapy.

The past medical history revealed that the patient was allergic to penicillin and had a single attack of wheezing dyspnea six months prior to admission. Review of systems was essentially noncontributory except that he had complained of pain in his shoulders and arms for approximately one year. The pain was accentuated by activity and had become worse

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several months prior to his hospitalization, at which time he also noted numbness and tingling of both hands.

Physical Examination

The patient was thin, appeared chronically ill, and was unable to give any information. He was confused, tachypneic, poorly responsive, and had difficulty speaking. The pulse and blood pressure were unobtainable in the upper extremities. The apical pulse was 72 per minute and regular. The rectal temperature was 98.8°F. The ears, nose and throat were normal. The conjunctivae were pale, the pupils were equal and reacted to light and accommodation, and the fundoscopic findings were normal. The neck was supple; there was no palpable lymphadenopathy or enlargement of the thyroid. The carotid pulsations were strong bilaterally and no bruit were heard. The lungs were dull to percussion in both bases, with decreased breath sounds and moist rales in the left base posteriorly. The heart was questionably enlarged; it had a regular sinus rhythm and no murmurs, thrills or gallops were noted.

The abdomen was somewhat distended and tympanic; no organomegaly was noted. There was dullness to percussion in the right upper quadrant 5 to 6 cm. below the right costal margin. On rectal examination the prostate was small, firm, and smooth. The extremities showed no edema, cyanosis, or clubbing of the fingertips. The only palpable peripheral pulses were those of both carotid arteries and the right femoral. The skin was cool, dry, and scaly with multiple excoriations. On neurologic examination the patient was markedly confused and poorly responsive with definite dysarthric speech. The ankle jerks

were absent bilaterally; the other deep tendon reflexes were present and no pathologic reflexes were noted.

Laboratory Data

On admission, the hemoglobin was 6.7 Gm., the leukocyte count 11,150 with 91 per cent neutrophils; platelet count 737,000; reticulocytes 4.8 per cent. The urine had a specific gravity of 1.014, pH of 5.5, contained 40 mg. of protein per 100 ml., and had 40 to 50 white blood cells per high power field and 3 plus bacteria. On admission the serum sodium level was 135 mEq., potassium 3.7 mEq., chloride 90 mEq., and the CO₂ combining power 35 mEq. per liter; calcium 3.9 mEq. per liter; total protein 7.2 Gm. (albumin 3.5 Gm., globulin 3.7 Gm.); uric acid 15 mg./100 ml. The blood urea nitrogen was 46 mg., creatinine 2.9 mg., and the fasting blood sugar 123 mg./100 ml. Sputum culture taken on admission grew no pathogens. The bone marrow revealed normal myeloid elements, slightly decreased megakaryocytic elements, and 8.5 per cent mature plasma cells.

An electrocardiogram revealed premature ventricular contractions, broad-notched P waves consistent with left atrial enlargement, prolonged atrioventricular conduction time, and ST and T wave changes probably secondary to digitalis.

The chest x-ray examination showed the heart to be grossly enlarged. The left costophrenic angle was obliterated; considerable pulmonary congestion was noted bilaterally. The x-ray findings in the skull were considered normal.

Hospital Course

On admission, the patient was given intravenous fluid therapy and antibiotics and was continued on digoxin, which had been started at his local hospital. He received a transfusion with 2 units of packed red cells and was started on intravenous Cytoxan®, 150 mg. daily. The patient did poorly and continued in respiratory distress. He remained afebrile until the tenth hospital day. A repeat sputum culture taken on this day yielded a heavy growth of coagulase-positive *Staphylococcus*. On the 12th hospital day the patient suddenly died.

CLINICAL DISCUSSION

DR. WALL: This is a fascinating case and should generate a lot of interest. Dr. Tennenbaum will discuss the case.

DR. TENNENBAUM: Before going rapidly over the salient features of this very complex case, I think there are two important points that we must remember: first of all, that his illness was chronic—it lasted at least one year—and second, it represented a multisystem disease. There is hardly a system in this man's body that was not involved—central nervous system, G.I. tract, vascular disease, renal disease, myocardial disease, pulmonary involvement,

hematological disease, and finally skin lesions. Let's quickly cover some of the salient features in the history.

First of all, he had fatigue and pallor for a year. We are then told that he had some symptoms compatible with peptic ulcer and later had other abdominal problems and was operated on with an acute surgical belly for so-called appendicitis. We also are told that he had no pulses and that one could not take his blood pressure, and finally this man had episodes of what seemed to be fleeting strokes. Two weeks prior to his last hospital admission a significant thing happened: he had severe pain in his legs and his back and then he deteriorated rather rapidly.

Laboratory studies at another hospital tell us that he had an anemia, he had some probable urinary tract infection with nonspecific findings in the urine at this time, he had a total protein which was normal but a marked abnormality in the A/G ratio. His bone marrow showed 15 per cent typical plasma cells with some immature forms. We are then told that he was allergic to penicillin and he had a wheezing episode. He then had pain in his arms and shoulders and perhaps had some evidence of peripheral neuropathy.

The physical examination when he came into this hospital showed that he was quite ill. He had severe anemia and he had evidence of probable failure. We are told that he had evidence of congestion in his lungs and questionable cardiomegaly on physical examination and possibly liver enlargement by percussion. He had some skin lesions that were really nondescript. The neurologic examination helps us very little in localizing any specific central nervous disease.

With reference to his laboratory work, I would like to know, first of all, Can we prove what type of anemia this man had? Did he have a repeat reticulocyte count? Do we have a bilirubin for possible hemolysis? Do we have a Coombs' test? Was a repeat bone marrow done? Finally, did they look for Bence Jones proteinuria? and was a protein electrophoresis done on this admission?

DR. THOMPSON: There were several spot checks for Bence Jones protein and a 24-hour urine examination for Bence Jones protein, which were all negative. The character of the anemia was really not gone into; however, the patient's reticulocyte count did rise during his hospital stay to a level of 8-9 per cent. There was no obvious jaundice mentioned and no bilirubin was done.

DR. BOURONCLE: The megakaryocytes were slightly reduced, the myeloid cells were normal, erythroid cells were somewhat decreased. There were numerous normal-looking plasma cells, some of them in clumps.

DR. TENNENBAUM: We are then told that his EKG had some abnormalities which are rather non-

specific. I have two particular questions: Were there any R waves present from V-1 to V-3? and was there low voltage?

DR. THOMPSON: There was not low voltage. I can't tell you about the R waves.

DR. TENNENBAUM: Could we have the x-ray report?

Radiologist's Discussion

DR. DUNBAR: He had a normal skull and a moderately enlarged heart with evidence of left ventricular failure and passive pulmonary congestion. I see no evidence of rib notching by which one could possibly incriminate aortic thrombosis.

DR. WALL: Why are you mentioning rib notchings? Will you elucidate on the rib notchings?

DR. DUNBAR: Well, when one gets thrombosis of the aorta, one has to get blood from the proximal aorta to the distal. The common channels are through the intercostal vessels, down the thoracics and internal mammaries, and the ribs notch because of the enlargement and tortuosity of the intercostal vessels carrying blood. If you have an obstruction of your proximal subclavian artery and need blood in the arms, you will then have flow from the distal aorta back into the intercostals and into the subclavian vessels. You have the reverse situation with coarctation of the aorta, and either situation can give you rib notching.

DR. TENNENBAUM: He was then treated for failure and was given transfusions, Cytosan, got a staph infection, and died suddenly.

Aortic Arch Syndrome

The first thing I was struck with in this case was the outstanding feature of his having no pulses. Did this man have so-called Takayasu's disease? However, this disease affects women, generally between the ages of 18 and 40, and only a very few cases have been described in a man. If the carotids are involved, there are symptoms of severe carotid and ocular insufficiency. The aortic arch can be involved by itself, but there have been some cases that have been described in which the abdominal vessels have been involved. I think we can quickly rule it out. It certainly does not explain his hematologic problems.

Of the other causes of the aortic arch syndrome the most common one is syphilitic aortitis with or without aneurysm. Rather surprisingly, arteriosclerosis itself is a rather uncommon cause of complete obstruction of the large arch vessels. Arterial embolism, chronic dissecting aneurysm, trauma, and finally nonsyphilitic aortitis of obscure origin should also be considered as diseases that occur later in life. This obscure aortitis has been thought to be perhaps due to something like periarteritis or rheumatoid disease. However, I don't think we have any evidence to support this as the primary cause of this man's vascular problem.

Multisystem Disease—Polyarteritis?

The multisystem disease is very prominent, and I think whenever you think about multisystem diseases you must think of a collagen disease. The one most likely would be polyarteritis. We can explain the fleeting central nervous symptoms, the G. I. symptoms on vascular insufficiency and his renal disease. However, with renal disease they usually get severe hypertension, and although we could not get a blood pressure reading, we have no evidence from his eyegrounds that hypertension had been very marked. In considering this disease, however, the penicillin allergy and the wheezing dyspnea may be used as support for it. Periarteritis has been associated with drug allergies and asthma-like attacks have occurred with this syndrome. We can't explain his large vessel disease as this disease primarily involves medium-sized and smaller vessels. However, if we would accept that perhaps the aortic arch syndrome could be caused by periarteritis, we might have a good case for this. The gamma globulin peak in his serum is not seen with periarteritis, and I think the anemia is a little bit more severe than one usually sees in periarteritis.

Occult Malignant Tumor?

The next thing that I thought perhaps might explain his symptoms would be an occult malignancy, and obviously we can't say that he did or did not have it if it were occult. However, many systemic symptoms from CNS to neuromuscular symptoms have been associated with an occult lesion, and, interestingly, the CNS symptoms are generally those of a rapidly deteriorating dementia. He may have peripheral neuropathies and they may be multiple hematologic abnormalities. One fascinating presentation of an occult malignancy is secondary amyloidosis, which could explain much of this man's problem, including the increased plasma cells found in the bone marrow. Perhaps we could make a good case for carcinoma of the pancreas with secondary amyloidosis. However, I don't think he had it. A lot of his problems could not be explained by this association, particularly the gamma globulin spike, although there have been a few rare cases of carcinoma with gamma globulin spikes.

Multiple Myeloma

I would now like to center my attention on what I *really* think this man had, and there are four pieces of evidence that you cannot get away from to make this diagnosis. First of all, he had an increased amount of plasma cells in the bone marrow. Second, we have evidence that he probably had a hemolytic anemia. Third, he had uricemia, and fourth—as the most important finding—he had an abnormal protein electrophoresis. Based upon this evidence, I think this man had multiple myeloma. However, I think that I ought to discuss each point and explain why I think so.

First of all, what about the plasma cells? They can be increased in diseases other than multiple myeloma. Above 5 per cent plasma cells are seen with carcinomatosis, rheumatoid arthritis, syphilis, aplastic anemia, cirrhosis, dysgammaglobulinemia, sarcoidosis, and tuberculosis. I don't think we have one shred of evidence that points to any one of those except perhaps for carcinomatosis. Multiple myeloma by definition states that there have to be abnormal plasma cells, and we are told that the cells on the first biopsy in another hospital were immature, but on the examination at this hospital they were reported as normal. Perhaps a repeat biopsy in another area would have given us the answer. Several cases, though, have been reported with a paraproteinemia which have been followed for up to 10 years with no evidence of any disease until they finally ended up with myeloma.

The evidence for hemolytic anemia is the fact that there was apparently no blood loss and that he had an elevated retic count. We have no evidence that the man was treated with anything prior to his admission to the hospital that would raise his red cells. So therefore I think we have evidence of hemolysis, although bilirubin and perhaps other studies would have been helpful. A Coombs' test would have been important to help us decide whether he had an immune type of hemolytic anemia, which can be associated with many hematologic problems. I don't want to go into them, but the most likely in this case would be myeloma. Nonimmune hemolysis has been associated with secondary hypersplenism and we have no evidence for that.

Hyperuricemia

His hyperuricemia is another factor that makes me think that this man had a malignant blood dyscrasia. Although he had mild renal insufficiency, the severity of his hyperuricemia is out of proportion to the degree of his renal failure. We are not given any clues that would lead us to think that he had primary hyperuricemia. Therefore we are left with secondary hyperuricemia which in most cases is hematologic in origin. Since we have no evidence for leukemia, lymphoma, pernicious anemia, and other diseases associated with uric acid increase, we end up with three diseases: multiple myeloma, Waldenström's macrogammaglobulinemia, and primary hemolytic anemia. Since we have no evidence that he had primary hemolytic anemia, we are left with the two paraproteinemias. In malignant hematologic diseases the pathogenesis of the increased uric acid is the increased metabolic rate and turnover of the malignant cells. Chemotherapy will often precipitate or aggravate it, which is a thing to remember in order to prevent a patient from going into renal failure from uric acid nephropathy.

The most important factor to be considered is his abnormal serum electrophoresis. Myeloma is the most common cause of a single elevated spike; how-

ever, there have been a few cases reported in which myeloma has produced two distinct spikes suggestive of both gamma A and gamma M abnormalities. Other possibilities for such a phenomenon include macroglobulinemia, primary amyloidosis, lymphosarcoma, and carcinoma. I don't think he had the last three that we mentioned, although macroglobulinemia seems a distinct possibility. However, those patients usually have in addition to their anemia visual and auditory disturbances, frequent infections, bleeding tendencies, prominent lymphadenopathy, and hepatosplenomegaly, and tortuosity and distention of their retinal veins. Thus I think we can arrive at the diagnosis of myeloma.

Against Myeloma—

However, there are certain features that we must explain: Why did he have negative x-ray findings? There is an important group of patients who present themselves with normal x-ray pictures the first time you see them and their problems—anemia, impaired renal function, infections, and symptoms secondary to amyloidosis—are extraskkeletal in nature. Secondly, these patients don't always have to have lytic lesions but may have diffuse osteoporosis. There was no evidence of this on these films; however, it would have been nice to see what his vertebral column looked like.

What about his renal insufficiency? Fifty per cent of patients with multiple myeloma have some type of renal involvement. Amyloidosis may be a problem in this case. In about 10 to 15 per cent amyloidosis complicates myeloma. The material does not have the staining characteristics of true amyloid; however, the distribution is that of primary amyloidosis—in other words the heart, the tongue, the blood vessels, and sometimes the kidneys are involved. It is usually associated with Bence Jones proteinuria by the heat test, but several cases have been reported in which Bence Jones proteinuria by the heating test was negative but was found to be present by using more sensitive technics. He certainly didn't have one of 8 or 9 Gm. per cent, which you might see with these cases. I don't think that this patient had amyloid of the kidneys because of the absence of marked proteinuria which is usually associated with it.

The term "myeloma kidney" refers to renal insufficiency associated with Bence Jones proteinuria, and it is thought that the Bence Jones protein has some kind of toxic effect on the renal tubules. Fifty per cent of myeloma patients have classic Bence Jones proteinuria; however, this man didn't seem to have had it, but we didn't do any specific tests such as immunoelectrophoresis or immunodiffusion, or even protein electrophoresis of the urine. Based on the fact that he had negative Bence Jones proteinuria, I doubt that the patient had true myeloma kidney.

The patient also did not have hypercalcemia to explain his renal failure, which is a common finding

in multiple myeloma. We also observe that renal failure may be rarely caused by myeloma cells invading the kidneys. I think that this man had a poor immunologic response, which these patients often have with hypogammaglobulinemia, that he got recurrent infections such as pyelonephritis. The hyperuricemia can also be a factor in his renal failure and may have produced uric acid nephropathy. However, I can't rule out that his renal artery or vein was involved by the same process that involved his aortic arch.

Finally, to go out on a limb, although we don't have much evidence from his EKG, I think the patient had amyloidosis of the heart with resultant pulmonary congestion. Of course, the vascular problem that he had involving the arch of the aorta would be sufficient except that we don't have evidence of enlarged ventricles. We also know that he had some skin lesions; he had symptoms of peripheral neuropathy, and he had liver enlargement, and I think amyloid depositions would account for all three of these, and I see no reason why the heart would not be involved.

I am at a loss, really, to explain all his vascular CNS problems, although the serum viscosity is up in patients with multiple myeloma with high proteins, and you get impaired circulation with resultant CNS symptoms, which is called coma paraproteinemia. So possibly he had that. I think he probably had arteriosclerosis with thrombosis because of the sludging effect that one gets in myeloma. I don't understand, however, why his eyegrounds didn't reveal whether he had arteriosclerosis or any other vascular abnormality of his retinal vessels. I think that his abdominal symptoms can all be explained on the basis of vascular insufficiency. As to the cause of death, the man apparently contracted a staphylococcal pneumonia on top of his heart failure, but I don't think this was the cause for his sudden death. I think that he probably had an acute cardiac arrest due to cardiac amyloidosis.

In summation then, my diagnosis is multiple myeloma with amyloidosis involving the heart, probably the skin, perhaps minimally the kidneys and also the liver; congestive heart failure and pneumonia; renal insufficiency due to a combination of pyelonephritis and uric acid nephropathy, and severe arteriosclerosis of the aorta and its major abdominal and thoracic branches.

General Clinical Discussion

DR. WALL: Dr. Penn did some postmortem studies on his protein which I think would be interesting at this point.

DR. PENN: By paper-strip electrophoresis of his serum, we found a marked depression of albumin, with an increase in very specific M-protein and a significant depression of normal gamma globulin.

DR. WALL: I wonder if Dr. McCoy would comment on the possibility of a Zeek type sensitivity polyarteritis which would explain his obliterative arterial disease?

DR. MCCOY: His vascular problems bother me too, and I just wonder whether Dr. Tennenbaum is willing to accept a hypersensitivity angiitis, which is often associated with the so-called paraproteinemias, as an additional diagnosis.

DR. WALL: Would you comment on the incidence of myeloma in pre-existing collagenosis?

DR. MCCOY: You are more of an expert on this than I am, but I guess that 10 to 15 per cent of the patients are reported with both conditions.

DR. WALL: I don't know that it is that high, but I think that patients with long-standing scleroderma and lupus often die with symptoms indistinguishable from myeloma.

DR. TENNENBAUM: My only problem is whether he also had a periarteritis or a hypersensitivity disease is that I could not find anything that indicated that such large vessels as the aortic arch could be involved.

DR. WALL: I would like to call on some of our third and fourth year experts. Podolny suggests that the patient might have multiple myeloma with cryoglobulinemia and para-amyloidosis, possibly with pulmonary artery thrombosis, bowel obstruction, and sepsis. Why would you think he had para-amyloidosis? and is there any evidence to suggest cryoglobulinemia?

MR. PODOLNY: Elevated cryoglobulins have been associated with multiple myeloma, and I thought it might explain the whole picture.

MISS CLAUSEN: I just have one comment to make about the vascular disease that this patient presented. The paracollagenous amyloidoses are characterized by plasma cell disease, and the paracollagen amyloid is usually deposited in the larger arteries and veins to the point that the vessels may be totally occluded by amyloid masses. I think in this particular case, whether he is one of these primary amyloidoses with plasma cell disease or a myeloma with secondary amyloidosis, his vascular obstruction is quite easily explainable.

DR. TENNENBAUM: I think we have two pieces of evidence that this may be a malignant blood dyscrasia. The hyperuricemia I think is out of proportion to the renal failure, and I have not often seen hemolytic anemia with primary amyloidosis. So these two facts made me go for multiple myeloma as a primary diagnosis.

DR. MENGEL: I would like to make two points: First, there is considerable doubt cast on the fact that the fundoscopic examination on this man was negative. I would contend that with complete fundoscopic

examination this man could not possibly have been negative. I say this because in every patient who has had this kind of protein abnormality, a gentle pressure on the eye and slowing of flow will demonstrate to you the most remarkable and delightful sign of sludging and turbulence of flow, which indeed we have used many times anterospectively to diagnose myeloma, amyloid, and less frequently dysproteinemia.

The other point that I did think bears attention had to do with hemolytic anemia, and I would like to say that I would take very, very strong issue with the claim that this patient had hemolytic anemia. If we utilize reticulocytosis, urobilinogen increases in the urine, or indirectly reacting bilirubin alterations in the serum as secondary manifestations of hemolysis, reticulocytosis is the least important, least dependable, and least specific of the findings. Another point which I think is even more important is that the occurrence of hemolytic anemia, proven by actual demonstration of shortened survival of red cells, is unusual in multiple myeloma. In general, most people will ascribe moderate elevations of reticulocyte counts to "irritative" phenomena of the bone marrow and consider unexplained reticulocytosis very frequently as the only clue to the presence of a myelophthisic process, a tumor in the marrow, or perhaps in this case myeloma.

CLINICAL DIAGNOSIS

1. Multiple myeloma.
2. Amyloidosis involving heart, skin, kidneys, and liver.
3. Congestive heart failure.
4. Staphylococcal pneumonia.
5. Chronic pyelonephritis and uric acid nephropathy.
6. Severe arteriosclerosis of aorta and major branches.

PATHOLOGIC DIAGNOSIS

1. Diffuse myelomatosis of bone marrow.
2. Amyloidosis involving the heart and vessels.
3. Multiple vascular thromboses.
4. Bilateral bronchopneumonia.
5. Septicemia.

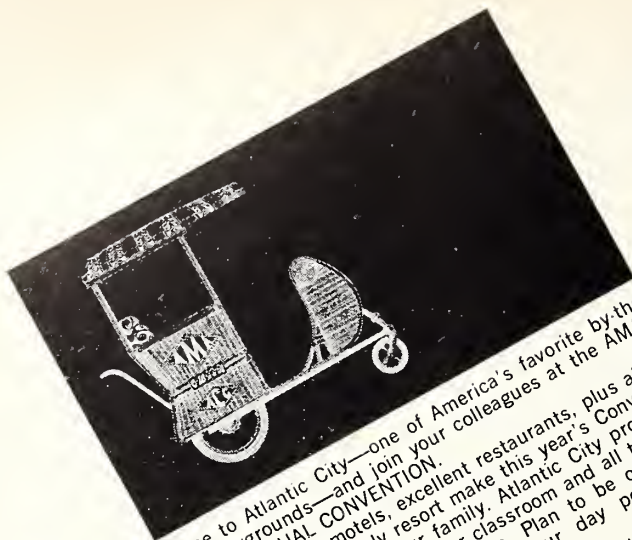
DISCUSSION OF THE PATHOLOGY

DR. VON HAAM: The skin showed a few petechial hemorrhages and some old scars. His heart weighed 500 grams, and numerous small mural thrombi were found in both ventricles. The myocardium had the gritty consistency of a raw potato and was pale reddish-brown. The valves appeared normal. The coronary arteries were slightly sclerosed. The lungs were heavy and showed numerous areas of consolidation with some recent infarction. The spleen weighed 150 grams. The splenic artery showed a large recent thrombus. The liver was enlarged, firm, and mottled. Some of the hepatic arterioles appeared occluded by thrombi. The lower part of the ileum appeared extremely congested and friable. The superior mesenteric artery was filled with a large thrombus measuring 3 cm. in length. The kidneys were unequal in size and the surfaces showed numerous recent and old infarcts. The muscles were pale and waxy. The bone marrow was pale reddish, but no lytic lesions could be observed.

On microscopic examination the most prominent finding was the appearance of pink-stained homogeneous material which gave a positive stain reaction for amyloid in the heart muscle and the walls of the larger and smaller vessels. No parenchymatous amyloidosis was present. Sections through the lungs showed a severe recent bronchopneumonia with numerous bacterial colonies. Sections through the kidneys showed some protein casts in the tubules and extensive amyloidosis of the renal vessels. Examination of all lymph nodes which were enlarged showed heavy infiltration with plasma cells. A similar diffuse infiltration without tumor formation was noticeable in the bone marrow. This was accompanied by a hypoplasia of all the blood-forming elements.

In conclusion then, we can state that the patient suffered from myeloma with diffuse myelomatosis, complicated by severe amyloidosis involving principally the heart and the large vessels. The patient died from a superimposed infection with coagulase-positive staphylococci and septicemia. I would like to congratulate Dr. Tennenbaum for his correct diagnosis and for his lucid explanation of the information given him which led him to make this diagnosis.

TEACHING HOSPITALS ought to provide as wide an experience of disease as possible, but their aim should be primarily to emphasize clinical methods and not to be comprehensive. — Alastair Hunter, M.D., F.R.C.P., London: *British Medical Journal*, 2:552-557, September 4, 1965.



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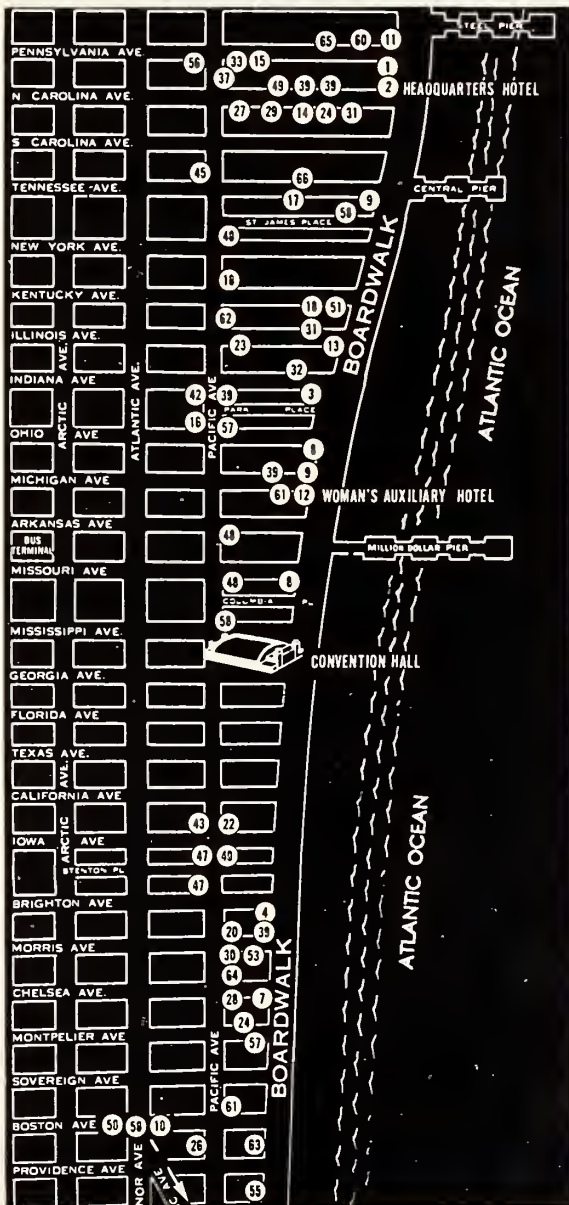
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JUNE 18-22, 1967

ATLANTIC CITY - HOTELS & MOTELS

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MAP NO.	BOARDWALK HOTELS	SINGLES	DOUBLES	TWINS	SUITES
1.	ABBEY.....NAC	10-12	12-14	16-20	
2.	CHALFONTE— HADDON FALL*	(HEADQUARTERS HOTEL— NO ROOMS AVAILABLE)			
3.	CLARIDGE HOTEL*	10-26		14-30	58-88
4.	DEAUVILLE HOTEL*	14-20		16-28	45-130
5.	DENNIS HOTEL*.....PAC	11-21		15-34	46-95
6.	HOLIDAY INN OF ATLANTIC CITY*	12-20	17-19	16-24	40-82
7.	LA CONCHA HOTEL*	12-14		16-24	35-75
8.	MARLBOROUGH-BLENHEIM* (Ocean Wing Only).....	21-25		21-25	42
9.	MAYFLOWER HOTEL*.....PAC	8-10	10-12	10-16	20-24
10.	PRESIDENT HOTEL*.....PAC	11-20		11-20	23-50
11.	SEASIDE TOWER HOTEL*.....	12		14-22	44-60
12.	SHELburne— EMPRESS HOTEL*.....	(WOMAN'S AUXILIARY HEADQUARTERS)			
13.	TRAYMORE*.....PAC	8-22		10-24	25-100

Map No.	OFF-BOARDWALK HOTELS	Singles	Doubles	Twins	Suites
14.	CAROLINA CREST HOTEL.....PAC	10-12	12	12-14	
15.	COLTON MANOR HOTEL*.....PAC	12-21		15-24	42-72
16.	EASTBOURNE HOTEL.....PAC	7-9	10	11	
17.	FLANDERS*.....NAC	8	10	14	
18.	STERLING.....PAC	10-12	12-14	12-14	

Map No.	MOTELS	Singles	Doubles	Twins	Suites
19.	ACAPULCO MOTEL.....	12	14	16-20	
20.	ALGIERS MOTEL*.....	12-14	14-16	12-20	45
21.	ALOHA MOTEL.....	14-16		14-28	
22.	ASCOT MOTEL.....	14-16		14-18	
23.	BALA MOTEL.....	12-18		16-24	
24.	BARBIZON MOTEL INN.....	11-13	15	17-23	60
25.	BARCLAY MOTOR INN.....	20-28		20-30	55-65
26.	BLAIR MOTOR INN.....	12-16		16-22	
27.	BURGUNDY MOTEL.....	12-16		16-26	
28.	CARIBE MOTEL.....	10-12	12	14-18	
29.	CAROLINA CREST MOTEL.....	14-16		14-16	
30.	CASTLE ROC MOTEL.....	14	14-20	14-20	40
31.	CATALINA MOTEL.....	14-20		14-18	
32.	COLONY MOTEL*.....	10-22		12-24	45-80
33.	COLTON MANOR MOTEL*.....	22-28		24-30	54-90
34.	CONTINENTAL MOTEL.....	14-16		14-20	
35.	CORONET MOTEL.....	16-22	18-26	16-24	50-60
36.	CRILLON MOTEL.....	16-22		18-24	
37.	CROWN MOTEL.....	14	16	18	
38.	DEAUVILLE MOTEL*.....	14-24		16-32	100-130
39.	DENNIS MOTEL*.....	15-25		15-29	
40.	DIPLOMAT MOTEL.....	10-12		14-24	30-36
41.	DUNES MOTEL.....	16	16-20	16-20	
42.	EASTBOURNE MOTEL.....		16-20	16-24	
43.	ELDORADO MOTEL.....	16		14-18	
44.	ENVOY MOTEL.....	10	12	14-16	
45.	FIESTA MOTEL*.....	14-16		16-22	35
46.	FOUR SEASONS MOTEL.....	14-18		18-24	
47.	GALAXIE MOTEL.....	12-16		10-16	
48.	HOWARD JOHNSONS*.....	14-18	14-18	18-30	44-90
49.	LA FAYETTE MOTOR INN*.....	(CO-HQS HOTEL NO ROOMS AVAILABLE)			
50.	LINCOLN-ROOSEVELT BEACH MOTEL.....	16-18		14-20	18-28
51.	LOMBARDY*.....	12-24		14-26	
52.	MALIBU MOTEL.....	12-14		16-20	
53.	MARDI GRAS MOTEL.....	14-16		16-22	25
54.	MAYFLOWER MOTEL*.....	10-12		10-16	
55.	MONTE CARLO BEACH MOTEL.....	11		13-15	
56.	MONTEREY MOTEL.....	14-16	14-16	18-20	
57.	MOUNT ROYAL*.....	12-24		14-26	
58.	PAGEANT MOTOR INN MOTEL*.....	16-20		18-26	40-44
59.	PRESIDENT MOTEL*.....	13-22		13-22	
60.	SEASIDE MOTEL*.....	14		16-22	
61.	SHELburne— EMPRESS MOTEL*.....	12-24		14-34	
62.	SORRENTO MOTEL*.....	10-14		16-22	
63.	STRAND OF ATLANTIC CITY MOTEL*.....	10-14		13-17	
64.	TEPLITZKY'S MOTEL.....	14		14-18	
65.	TERRACE*.....	14		16-22	
66.	TRINIDAD MOTEL.....	14-16		16-28	
67.	TROPICANA MOTEL.....	8	10-12	14-18	20-24

*Restaurant and/or Coffee Shop on premises

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Veterans in Outpatient Plan May Choose Own Doctor

A new program to reduce costs and improve service in outpatient care is being inaugurated by the Veterans Administration following a successful test program in three states.

Since World War II, the Veterans Administration has authorized outpatient care by private doctors, at government expense, for certain qualified veterans. Most of these patients have service-connected disabilities. Hometown medical care is authorized in such cases when treatment at a VA medical facility would involve a long trip or other hardship. Under the old rules, VA estimated how much care each such veteran would need during the coming year and issued an authorization to a specific doctor to give treatment at government expense.

Under the new program, VA will issue an identification card to veterans who require this type of treatment, and each patient will be permitted to select a doctor of his choice for treatment of the medical condition stated on his card.

Tests of the new system—conducted in Indiana, Colorado and Alabama—demonstrated that administrative costs of providing this treatment were reduced significantly.

Both the patient and the doctor also benefit by the new plan. The patient can visit the doctor of his choice as often as his doctor considers necessary. The doctor is relieved of much of the paper work associated with the old system, according to VA. Instead of preparing a medical report and a claim form, he merely files an itemized bill on his own letterhead just as he does for his other patients. Medical reports to the VA are filed by the doctor only when there is a significant change in the veteran's service-connected condition.

Dr. Joseph E. Brown, chief of orthopaedic surgery at St. Luke's Hospital, Cleveland, is the new president-elect of the Clinical Orthopaedic Society, Inc. He will take office as president at the organization's meeting in Columbus next fall.

Assistant Professor Carolyn Burnett of the School of Allied Medical Services, Ohio State University, is heading a project in which toddlers are filmed to gain further information on the walking patterns. As the project develops, physicians and others will be able to view the films which will visually illustrate gait sequences in the developing process.

Dr. W. Hugh Missildine, Columbus, spoke at a dinner meeting of the Champaign County Education Association in Urbana, relating his talk to the child psychiatric field in which he specializes.

Tandearil® oxyphenbutazone

Therapeutic Effects: Tandearil is a nonhormonal compound which may rapidly resolve inflammation and help restore normal joint function. Its action does not affect pituitary-adrenal function or impair immune responses. Its value in osteoarthritis is especially noteworthy because this disorder responds inconsistently to steroids and is often resistant to salicylates. Further, indomethacin is limited only to osteoarthritis of the hip, whereas oxyphenbutazone is effective in all forms of the disease.

Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently.

Warning: If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Pyrazole compounds may potentiate the pharmacologic action of sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with great caution in the first trimester of pregnancy.

Precautions: Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should be closely supervised and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools or other evidence of intestinal hemorrhage. Make regular blood counts. Discontinue the drug and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The most common are nausea, edema and drug rash. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. Infrequently, agranulocytosis, or a generalized allergic reaction may occur and require withdrawal of medication. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

Dosage in Osteoarthritis: The initial daily dosage in adults is 300-600 mg. in divided daily doses. When improvement occurs, dosage should be decreased to the minimum effective level; this should not exceed 400 mg. daily, and is often achieved with only 100-200 mg. daily.

For complete details, please refer to full prescribing information. 6562-VI(B)R

Availability: Tablets of 100 mg.



Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York

Policy Statements
REGARDING
GOVERNMENT MEDICAL CARE PROGRAMS

SECTION II

(Section I appeared in the May Issue, OSMJ)

Developed by the
Ohio State Medical Association Committee on Government Medical Care Programs
and Approved by
The Council, February 18-19 and March 18-19, 1967

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THIS is the second section of the presentation on Government Medical Care Programs. Section I appeared in the May issue. Each program is presented with an explanation of its activities and functions. Following this explanation are listed the policy statements as approved by The Council. The background information presented represents an explanation of the program as it is, not necessarily as OSMA feels that it should be. Therefore, the reader should not consider the explanatory information as representative of OSMA policy. For the OSMA President's introduction, and for the OSMA General Policy Statement Regarding Government Medical Care Programs, refer to pages 2 and 3 of the report in the May issue.

Aid for Aged, Blind, Dependent Children, and Disabled

BACKGROUND INFORMATION

The Department of Public Welfare Medical Assistance Program provides essential health services for eligible persons when required by their condition and for which they are not otherwise entitled from other sources. Medical Assistance is administered by the county welfare departments which also administer other forms of public assistance. The Medical Assistance Program is effective July 1, 1966.

1. Where to Apply

Application for Medical Assistance may be made to the county welfare department located in the county in which the applicant resides.

2. Who is Eligible

Medical assistance is available to:

a. All recipients of aid of the programs of Aid for the Aged, Aid to the Blind, Aid to Families with Dependent Children, and Aid to the Permanently and Totally Disabled.

b. All children under 21 who would be eligible for Aid to Families with Dependent Children except that they are not attending school.

c. Any individual who would be eligible for aid in the categories listed in (a), above, except for residence requirements. These individuals are not required to give a lien on property as a condition of eligibility.

3. Health Services Card

A health services card indicating an expiration date will be provided to each case. The

card indicates eligibility of the individual named for allowable health services, in the instance of the categorically related adult programs. For those recipients categorically related to ADC, the card indicates that the person named, a dependent spouse in the home and/or dependent children to age 21 in the case, normally are eligible for allowable health services. It provides the correct name and case number to be used in billing for health services and limited billing instructions. The cards are prepared and issued by the Division of Administrative Services, Department of Public Welfare.

4. Prior Authorizations

Prior authorizations for essential services are usually unnecessary. Practitioners, vendors, and providers of services should direct inquiries regarding prior authorizations to the county welfare department.

5. Benefits and Coverage

The program provides a wide scope of health care benefits:

A. Professional services including those of: Physicians, Dentists, Optometrists, Podiatrists, Chiropractors, and Limited Practitioners.

a. Medical Care

Individuals providing such services must be appropriately licensed by the state in their field of practice. The services of a Podiatrist and a Chiropractor are included within their

field of practice. Services of limited practitioners are provided if recommended by a physician licensed to practice medicine or osteopathy. The required professional services may be rendered in the patient's home, hospital, clinic, rest home, nursing home, office, or other appropriate place.

b. Dental Services

Dental Services available to recipients include all forms of dental care except orthodontia. Prior authorization is not required for elimination of pathosis and extraction of unsavable teeth, relief of pain and the treatment of acute infections or for diagnostic x-rays and examinations of the patient's mouth. Prior authorization is required for prosthetic dental services of all kinds.

c. Vision Care Services

Services provided include the examinations of the eyes, fitting and dispensing eye-glasses, including related professional examinations and material. The required vision care services may be provided either by an ophthalmologist or optometrist. Prior authorizations for necessary services are not required except for:

a. Procedures (including materials) involving a fee of more than \$35.00.

b. Prosthesis (such as artificial eyes) and other special examinations and services.

Basis of Reimbursement—Professional Services

Bills for professional services may be submitted on the basis of customary charges. Payment may be less than that charge, depending upon the maximum payments that are established by the Department of Public Welfare to maintain expenditures within appropriated funds.

Payments for medical care will be made for not more than two (2) visits for chronic illness and more than ten (10) for acute illness during any month.

B. Inpatient Hospital Services

Hospitals must notify the county welfare department of the admission of a recipient or applicant by utilization of the form "NOTICE OF HOSPITAL ADMISSION," (Form #5-PA-435), within 72 hours of admission to the hospital.

Acute Care Hospitals

Inpatient services will be provided in acute hospitals for illnesses, injuries, or disabilities

certified medically necessary by a physician. There will be no limitation on the number of days of hospitalization provided.

Recertification — Recertification will be required in each case of inpatient hospital services not later than the 20th day of hospitalization, and thereafter as required in procedures under Title 18 of P. L. 89-97. Recertification may be requested using Form OHA-101—Revised (Authorization Request—Extension of Payment for Hospitalization) or using an appropriate form developed for Title 18 recertification. Recertification requests will be submitted to the county welfare department for approval.

Utilization Review

For hospitalization of extended duration a Utilization Review, or comparable procedure, must be conducted as prescribed in or pursuant to regulations under Title XVIII, of P. L. 89-97. **Chronic Hospitals**

Chronic hospital services are provided when the patient is in need of treatment of chronic ailments (except tuberculosis or mental diseases) and/or rehabilitative services which require the facilities of the hospital for their administration. The Utilization Review procedure described under general hospitals will apply to recipients in chronic hospitals with the additional requirement that the attending physician must submit a statement that further chronic hospital services are required as opposed to nursing home care.

C. Outpatient Services

Three types of services are available for those who do not require inpatient care:

a. Clinic.

Clinics may be established by hospitals either for general medical services or for specific limited services such as orthopedics.

Basis of Reimbursement

Whenever there is an organized clinic the rate, as established annually, based on the financial report of the hospital for the previous calendar year will be utilized as the basis for reimbursement.

b. Diagnostic and Treatment Services

Outpatient diagnostic and treatment services will be available on the same basis and extent as those covered under the general scope of physicians' services. Such services include diagnostic, lab, and other tests. Necessary related

supplies are also provided including dressings, splints, casts, etc.

Basis of Reimbursement

If a hospital does not have an organized clinic but provides medical services to outpatients the charges should be related to the services rendered. If the charges are not itemized, payment will be based on the allowances for comparable physicians' services.

c. Emergency Service

Emergency services are those functions of a hospital which provide, in separate and adequate facilities, prompt emergency diagnosis and treatment.

Basis of Reimbursement

When emergency service is provided to the recipient, payment will be made at the audited cost rate for emergency service or if the hospital does not have an audited cost rate, at a rate not to exceed \$3.00 per visit.

D. Skilled Nursing Home Care

Up to 100 days of skilled nursing home care are provided during any spell of illness in a facility certified as an extended care facility under the requirements of Title XIX. County Welfare Departments and facilities will be notified when certified for this purpose. Hospitalization prior to admission to the extended care facility is not required. A spell of illness is defined as a period of consecutive days beginning with the first day (not included in a previous spell of illness) on which an eligible individual is furnished skilled nursing home services and ending on the close of the first period of 60 consecutive days thereafter on each of which he is not an inpatient of a skilled nursing home.

Basis of Reimbursement

Effective July 1, 1966, payment for care will be made not to exceed \$9.00 per day in such certified extended care facilities. An adjustment to the rate paid will be made after January 1, 1967, if indicated.

Effective January 1, 1967, payment will be made for care in such certified extended care facilities based on an established cost formula, not to exceed \$10.00 per day.

E. Home Health Services

The necessary services of visiting nurses are provided when rendered under the auspices and

supervision of a home health agency certified by the Department of Health.

Basis of Reimbursement

Reimbursement will be made to the agency on a cost per visit basis. If skilled nursing, including practical or registered nursing services are required, the maximum reimbursement will be based on the prevailing rate in the community.

F. Drugs and Medical Requisites

Physicians are requested to prescribe for their patients who are receiving medical assistance as they would for their private pay patients.

For purposes of payment the following drugs are classified as being essential:

a. All prescription-legend drugs (drugs which, by law, require prescriptions for dispensing).

b. Prescriptions for medications requiring special compounding by the dispensing pharmacist.

c. Non-prescription-legend drugs as listed in the Department of Public Welfare Publication "STANDARDS AND PROCEDURES FOR DISPENSING DRUGS AND MEDICAL REQUISITES." (#3083). This publication also describes other policies and procedures applicable to the drug program. The method of reimbursement and cost standards are also included.

G. Ambulance Service

Payment without prior authorization will be made under the following conditions.

a. There are no existing community or personal resources available.

b. Necessary transportation to or from a hospital at the time of admission or discharge.

c. When ordered by the attending physician or other person in authority, such as a policeman, in emergency situations. Prior authorization for ambulance service is required in all other circumstances.

Basis of Reimbursement

The usual charge for the service in the community.

H. Prosthetic Devices and Medical Equipment

Payment is authorized for prosthetic devices such as artificial limbs, braces, orthopedic shoes, hearing aids, wheel-chairs, and similar devices when prescribed by a physician. Standard type

prosthetic devices meeting the needs of the patient are authorized.

Prior authorization is required for any device costing in excess of \$35.00. When practical, the rental of equipment such as wheelchairs, should be given consideration if appropriate for the total treatment plan for the patient.

Basis of Reimbursement

Payment will be authorized for standard type devices and rental fees, based on the customary charges for such items and services in the community.

I. Hospital Insurance Program Under Social Security

For those individuals who are covered by Part A of Title XVIII (Hospital Insurance Program) full cost of any deductibles and co-insurance will be provided and paid on the same basis of reimbursement for other recipients. Hospitalization benefits provided by Part A of Title XVIII must first be utilized by eligible persons age 65 and over. No payment for care covered under Part A for such persons will be made with the exception of the deductibles and co-insurance previously described.

One copy only of the invoice is required for processing. Prior authorizations and prescription forms, if applicable to the services or the goods provided, must accompany the invoices submitted. Proper preparation of invoices and related attachments will assure reimbursement and avoid delays. Bills should be submitted within 30 days following the date or termination of service or as soon thereafter as possible. Payments made by the patient or other sources must be entered on the bill and deducted from the allowable amount for the service. Billing procedures apply to services and goods provided subsequent to June 30, 1966. Invoices for services and goods provided prior to July 1, 1966, should be submitted to the county wel-

fare department for processing. The following information is required on all invoices:

Name and address of practitioner or vendor
Name, case number, and category as indicated on the Health Services Card

Date and nature of service

Discharge diagnosis (applicable only to inpatient hospital invoices) Invoices for medical care services should state whether the case is acute or chronic.

Special requirements applicable to the drug billing procedures are described on form No. DPW 2079 (revised June 1966). Billing forms will be distributed to all participating pharmacists.

The Department of Public Welfare reserves the right to review any invoice and claim submitted for reimbursement regarding the nature of the services rendered, and whether the billing is appropriate and reasonable in amount.

Other Benefit Sources

Recipients may be eligible for health care services under other established programs. Payments will not be authorized for services provided to a recipient, except on an emergency basis, if the recipient would have been eligible for such services under another program.

Some examples of other such sources are:

- a. The Department of Public Welfare, Crippled Children Services Program
- b. Ohio Bureau of Workmen's Compensation
- c. Health Care benefits under Title XVIII of the Medicare Act
- d. Veterans Administration
- e. Free services available from Public Health Departments, etc.

7. Fair Hearings

Any applicant or recipient of medical assistance has a right to appeal a decision made

which he considers to be in conflict with his own interests. Such complaints may be directed to the county welfare department or in writing to the State Department of Public Welfare, Division of Welfare Administration, 9th and Oak Streets, Columbus, Ohio 43215.

8. Confidential Information

All information related to applicants and recipients and records thereof are considered privileged communications and shall be held in strict confidence and used and divulged for no

purpose except for the administration of the program or as otherwise provided.

Sources of Information

Questions regarding eligibility, benefits, etc., should be directed, as in the past, to the appropriate county welfare office.

Questions regarding general information may be addressed to:

Department of Public Welfare
Division of Health and
Rehabilitation Services
408 East Town Street
Columbus, Ohio 43215

POLICY STATEMENT

The Council adopted the following policies in regard to the Ohio welfare budget when it resolved:

1. That OSMA take appropriate steps to inform county medical society legislative chairmen of the need for an increase in the budget of the Ohio Department of Public Welfare, and of the approximate amount of increase needed, and recommend that these chairmen make contact with members of the Ohio House of Representatives and Ohio Senate from their areas regarding legislative support for such an

increase in the Ohio Department of Public Welfare Budget.

2. That the Ohio Department of Public Welfare develop a brochure which would explain the role and responsibility of the physician with regard to each of the four public assistance programs. This recommendation is made with the knowledge that most physicians although somewhat knowledgeable about the Aid for Aged program are not familiar with the operation of the Aid for Blind, Dependent Children, and Disabled programs.

Comprehensive Health Planning (P. L. 89-749)

BACKGROUND INFORMATION

Comprehensive Health Planning and Public Health Service Amendments of 1966

Congress declared in P. L. 89-749, among other things, that federal financial assistance should be directed to support the marshalling of all health resources—national, state, and local—to assure comprehensive health services of high quality for every person, but without interference with existing patterns of private professional practices of medicine, dentistry, and related healing arts. This bill would have the Congress find that comprehensive plan-

ning for health services, health manpower, and health facilities is essential at every level of government; that desirable administration requires strengthening the leadership and capabilities of state health agencies; and that support of health services in communities should be broadened and made more flexible.

National Health Policy

The law provides that in order to assure planning and direction on the national level leading to the construction of a national health

policy, the Surgeon General is authorized between July 1, 1966 and June 30, 1972 to conduct studies, research, and investigations to establish a "coherent" set of national health goals and to formulate comprehensive guidelines to assist the states in developing health plans consistent with the bill's purposes.

The law also amends the provisions of the Public Health Service Act relating to grants to states for the prevention, control, and treatment of specific diseases by completely revising them and substituting therefor a program of grants for comprehensive health planning and public health services.

Grants for Comprehensive State Health Planning

The law authorizes the Surgeon General, during the period of July 1, 1966 to June 30, 1972, to make grants to states which have submitted and have had approved by him state plans for comprehensive state health planning. To carry out the program, the law authorizes the appropriation of \$2.5 million in fiscal 1967, \$5 million in fiscal 1968 and \$10 million each in fiscal years 1969 and 1970.

In order to be approved, a state plan for health planning must:

(1) designate a single state agency (which could be an interdepartmental agency) as the sole agency for administering or supervising the administration of the state's health planning functions under the plan; (The Ohio Department of Health has been appointed the designee agency in Ohio by Governor Rhodes)

(2) provide for the establishment of a state health planning council which would have to include representatives of state and local agencies and nongovernmental organizations concerned with health and consumers of health services to advise the state agency in carrying out its functions under the plan;

(3) set forth policies and procedures for the expenditure of funds under the plan which, in the Surgeon General's judgment, are designed to provide for comprehensive state planning for health services, both public and private, including the facilities and persons required to provide such services to meet the health needs of the people in the state;

(4) provide for encouraging cooperative efforts among governmental and nongovernmental agencies concerned with health services

and facilities or manpower and for cooperative efforts between such organizations and similar organizations in the fields of education, welfare, and rehabilitation;

(5) contain assurances satisfactory to the Surgeon General that the funds paid for this purpose will be used to supplement and increase the level of funds which would otherwise be available to the state, and not to supplant such nonfederal funds;

(6) provide methods of administration, including a merit system for personnel, as are found by the Surgeon General to be necessary for proper and efficient operation of the plan (the Surgeon General would have no authority with respect to the selection, tenure, or compensation of any individual);

(7) provide that the state agency will make such reports as the Surgeon General may require and will keep records and afford access thereto as he finds necessary to assure their correctness;

(8) provide that the state agency will, at least annually, review its state plan and submit to the Surgeon General appropriate modifications thereof;

(9) provide for fiscal control and accounting procedures to assure proper disbursement of and accounting for federal funds; and

(10) contain such additional information and assurances as the Surgeon General may find necessary.

Funds under the program will be allotted to the states on the basis of population and per capita income. However, the minimum allotment to any state in any fiscal year can not be less than 1 per cent of the sums appropriated. An allotment for a state would remain available for obligation until the close of the succeeding fiscal year. An allotment which the Surgeon General determines will not be required by a state during the period for which it is available would have to be made available to the other states in proportion to their original allotments. However, no state could have an allotment which exceeds a sum that the Surgeon General estimates will be necessary to meet that state's needs.

From each state's allotment, the state will be paid the "federal share" of the expenditures incurred during that or the succeeding year pursuant to the state plan. The payments will

be made on the basis of estimates by the Surgeon General. The "federal share" under this program will be 100 per cent or such part of the cost of planning as the Surgeon General may determine. However, in the case of allotments for fiscal 1970 and the two succeeding years, the federal share can not exceed 75 per cent of the cost.

Grants for Areawide Health Planning

The Surgeon General is authorized, during the period of July 1, 1966 to June 30, 1972, with the approval of the state agency administering the plan for comprehensive state health planning, to make project grants to any other public or nonprofit private agency to cover up to 75 per cent of the cost of projects for developing (and for revising) comprehensive regional, metropolitan area, or other local area plans for coordination of existing and planned health services, including the facilities and persons required for such services. However, in the case of a project grant made in any state prior to July 1, 1968, approval of the state agency will be required only if the state has a state plan in effect at that time. To carry out the program, the bill would authorize the appropriation of \$5 million in fiscal 1967, \$10 million annually for fiscal years 1968, 1969, and 1970.

Project Grants for Training, Studies, and Demonstrations

The Surgeon General will be authorized, during the period July 1, 1966 to June 30, 1972, to make grants to any public or nonprofit private agency to cover all or any part of the cost of projects for training, studies, or demonstrations looking toward the development of improved or more effective comprehensive health planning throughout the nation. To carry out the program, the bill authorizes the appropriation of \$1.5 million in fiscal 1967, \$5 million annually in fiscal 1968, 1969, and 1970.

Grants for Comprehensive Public Health Services

The law authorizes the appropriation of \$170,500,000 for fiscal 1968 and \$230,700,000 annually for fiscal 1969 and 1970, to enable the Surgeon General to make grants to state health or mental health authorities to assist the states in establishing and maintaining adequate

public health services, including the training of personnel for state and local health work. The sums appropriated would be used to make payments to states which have submitted state plans which have been approved by the Surgeon General.

A state plan under this program must:

(1) provide for administration by the state health authority or, with respect to mental health activities, the state mental health authority;

(2) set forth policies and procedures to be followed in the expenditure of funds paid under this program;

(3) contain assurances satisfactory to the Surgeon General that (a) the funds paid to the state will be used to make a significant contribution toward providing and strengthening public health services in the various political subdivisions to improve the health of the people, (b) the funds will be made available to other public or nonprofit private agencies in accordance with criteria which the Surgeon General determines are designed to secure maximum participation of local, regional, or metropolitan agencies in the provision of services; and (c) the funds will be used to supplement and not supplant nonfederal funds; (d) public health services under the plan will be established and maintained for individuals confined in institutions for the mentally ill or retarded;

(4) provide for the furnishing of public health services under the plan in accordance with plans that have been developed under the program of grants for comprehensive health planning, and effective July 1, 1970, except to the extent permitted in regulation, that the services will be provided only to the extent included in and in accordance with such plans; and

(5) provide that the public health services furnished under the plan will be in accordance with standards prescribed by regulations, including standards as to scope and quality of services.

In addition, the state plan would have to provide for methods of administration, review, and evaluation, of the state plan, the making of reports, fiscal control and accounting procedures, and such other information as is required under the state plan for comprehensive health planning described above.

Allotments under this program will be on the basis of population and financial need of the states.

From each state's allotment, the state will be paid the "federal share" of expenditures incurred during the year under its state plan. In determining the federal share for a state, expenditures by nonprofit private agencies would, subject to any limitations prescribed by regulations, be regarded as expenditures by the state.

For the purposes of this program, the "federal share" will be based on a formula involving relative per capita income. However, in no case could the federal share for any state be less than $33\frac{1}{3}$ per cent nor more than $66\frac{2}{3}$ per cent. (The federal share for Puerto Rico, Guam, American Samoa, and the Virgin Islands will be $66\frac{2}{3}$ per cent.)

Federal shares will be determined by the Surgeon General between July 1 and September 1 of each year. Such a determination will be conclusive for the fiscal year beginning on the following July 1.

At least 15 per cent of a state's allotment under this program must be available only to the state mental health authority for the provision of mental health services. At least 70 per cent of that amount and at least 70 per cent of the remainder of a state's allotment under this program would be available only for the provision of services in the communities of that state.

Project Grants for Health Services Development

The law authorizes the appropriation of \$100 million for fiscal 1968, \$125 million annually for fiscal 1969 and 1970, for grants to public or nonprofit private agencies to cover part of the cost of:

- (1) providing services to meet the health needs of limited geographic scope or of specialized regional or national significance;
- (2) stimulating and supporting for an initial period new programs of health services; or
- (3) undertaking studies, demonstrations, or training designed to develop new methods or improve existing methods of providing health services. Grants could be made for the first two programs described above only if the services are provided in accordance with plans

which have been developed under the program for comprehensive health planning and, effective July 1, 1970, except as permitted in regulations, only to the extent such services are included in and are furnished in accordance with such plans.

Interchange of Personnel with States

The Secretary of HEW is authorized to arrange for the assignment of officers and employees of states to the Department of HEW and the assignment to states of officers and employees of that Department engaged in work related to health, for work which the Secretary determines will aid the Department in the more effective discharge of its responsibility in the health field, including cooperation with states and the provision of technical or other assistance. The period of an assignment can not exceed two years.

Officers and employees of the Department who are assigned to a state remain employees of the Department for all purposes except that their supervision would be covered by an agreement between the Department and the state involved. If an employee is assigned and placed on leave without pay and his rate of compensation for employment by the state is less than his rate of compensation with the Department, he could receive a supplementary salary payment from the Department in an amount considered by the Secretary to be justified but not in excess of the difference between the state rate and the Department rate.

Such an employee would also be granted annual leave and sick leave to the extent authorized by law. Such employees would also be entitled to have insurance under the Federal Employees' Group Life Insurance Act and coverage under the Federal Employees Health Benefits Act so long as the Department continues to collect his contribution and to transmit timely deposits to the appropriate funds. Such service would be credited toward periodic or longevity step increases and for retention and leave accrual purposes and, upon payment to the Civil Service Retirement and Disability Fund of the percentage of their state salary, such service would be construed as services for retirement purposes. However, no employee or his beneficiary could receive benefits under the federal retirement, health insurance or life insurance program based on such service for which he or his beneficiary has elected to re-

ceive benefits under a state program which the Civil Service Commission determines to be similar.

Any employee who suffers a disability or death as a result of a personal injury sustained while in the performance of his duties while on an assignment would be treated for the purposes of the Federal Employees' Compensation Act as though he were a federal employee who sustained the injury in the performance of his duty. When such a person is also entitled to benefits under a state law for the same injury or death, an election would have to be made as to which benefits would be received.

Assignment of any employee in the Department to a state could be made with or without reimbursement by the state for compensation, travel, and transportation expenses. Appropriations to the Department would be made available according to appropriate regulations to meet the travel expenses of individuals assigned to states, including transportation expenses for their immediate families and for household goods.

Employees of states who are assigned to the Department of HEW can be given appointments in the Department or be considered on detail to the Department. Appointments would be made without regard to the civil service laws. Persons appointed to the Department will be paid according to the Federal Classification Act but would not be considered employees of the Public Health Service for the purpose of the Civil Service Retirement Act, the Federal Employee's Group Life Insurance Act. Unless their appointment results in the loss of coverage in a group health benefits plan whose premium has been paid in whole or in part by the state, they would not be included in the Federal Employees' Health Benefits Act.

A state employee who suffers a disability or a death as a result of a personal injury will be treated for the purposes of the Federal Employees' Compensation Act as a federal employee. If such an individual is entitled to benefits under a state act for the same injury or death, he or his beneficiary would have to make an election as to which benefits will be received.

General

All regulations with respect to grants for comprehensive health planning will have to

be made after consultation with the conference of state health planning agencies designated in state plans for such purposes. Regulations with respect to grants for comprehensive public health services would have to be made after consultation with the conference of state health authorities or, in the case of grants for mental health, the state mental health authorities. Insofar as practicable, the Surgeon General would have to obtain agreement of the state authorities with whom the consultation is required.

The law provides for the withholding of funds under any of the above programs if there is failure by the state to comply substantially with the provisions of the bill, the state plan, or applicable regulations.

Grants for Graduate Public Health Training

The law authorizes the appropriation of \$5 million annually in fiscal 1968 and 1969 to enable the Surgeon General to make grants for the provision, in accredited public or non-profit private schools of public health, of comprehensive professional training, specialized consultative services, and technical assistance in the fields of public health and in the administration of state or local public health programs. In allocating funds among the schools of public health, the Surgeon General will have to give primary consideration to the number of federally sponsored students attending each school.

Miscellaneous

Beginning July 1, 1967, the provisions of the Public Health Service Act relating to federal-state cooperation will be amended by authorizing the Surgeon General to train personnel for state and local health work.

The Surgeon General must encourage cooperative activities between the states with respect to comprehensive and continuing planning of current and future health needs, the establishment and maintenance of adequate public health services and otherwise carrying out the above programs.

The provisions of the bill relating to grants for comprehensive state health planning, area-wide health planning, comprehensive public health services, health services development, and the interchange of personnel would be effective July 1, 1966, and existing law relating

to grants for areawide planning would be repealed as of that date.

However, the provisions of existing law relative to grants for categorical diseases would be effective in lieu of the program for grants for public health services or health services development contained in the bill until July 1, 1967. Effective July 1, 1967, the existing program of grants for community health services would be repealed.

Grants for Services at Mental Retardation Facilities

The law amends the Mental Retardation Facilities and Community Mental Health Centers Construction Act to provide a new program of grants for services.

In order to assist public and nonprofit private organizations, to initiate, extend and improve facilities for the mentally retarded, the Secretary is authorized to make grants for up to 75 per cent of the cost of providing services in such facilities. After June 30, 1968, the Secretary would have to give preference to new and expanded services part of the cost of which would be borne out of state or public funds.

Grants could be made only upon application and only if, (1) the applicant is a public or nonprofit private organization which owns or operates the facility; (2) the services to be provided will provide, principally for persons residing in a particular community in or near which the facility is located, one or more of the types of services for the mentally retarded which are determined by the Secretary to be basic and necessary; (3) the Secretary determines that the types of services to be supported are not sufficiently available in other facilities in the community; (4) the Secretary determines that with respect to the types of services to be assisted, federal financial assistance is not available to the applicant under any other Act administered by the Department of HEW; (5) the Secretary determines there is satisfactory assurance that federal funds made available for any period will be used to supplement and increase the level of nonfederal funds for mental retardation services and will in no event supplant state, local, and other nonfederal funds; (6) in the case of an applicant in a state which has in existence a state plan for the provision of services for the mentally retarded, the services to be provided by the facility are consistent with the plan.

The Secretary will prescribe general regulations concerning eligibility of facilities for grants, the determination of eligible costs and the terms and conditions for approving applications. Payment may not be made to any project for a period in excess of five years beginning with the commencement of the first fiscal year in which payment is made.

To carry out the above program, the bill authorizes the appropriation of \$1 million in fiscal 1967, \$7 million in 1968, \$12 million annually in fiscal 1969 and 1970.

The law amends the definition of "construction" under the Mental Retardation Facilities and Community Mental Health Centers Construction Act to include the acquisition and renovation of existing buildings. It also redefines "cost of construction" under that law to include the cost of architects' fees and acquisition of land in connection with construction but not the cost of off-site improvements.

The Training of Physical Education and Recreational Personnel for Mentally Retarded and Handicapped Children

The law amends the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963 by authorizing the Secretary to make grants to public and nonprofit institutions of higher learning to provide professional or advanced training for personnel (1) engaged or preparing to engage in employment as physical educators or recreation personnel for mentally retarded or handicapped children, or as supervisors of such personnel, or (2) engaged or preparing to engage in research or teaching in fields related to physical education or recreation of such children.

To carry out this program, the law authorizes the appropriation of \$1 million in fiscal 1967, \$2 million annually in fiscal 1968 and 1969. Sums not obligated during a fiscal year would remain available for the succeeding fiscal year.

The law also authorizes the appropriation of \$1 million for fiscal 1967 and \$1.5 million for each of the two succeeding fiscal years to be used by the Secretary to make grants to states, state or local educational agencies, public and nonprofit private institutions of higher learning, and other public or nonprofit private educational or research agencies, for research

or demonstration projects relating to physical education or recreation for mentally retarded, hard of hearing, deaf, speech impaired, physically handicapped, seriously emotionally disturbed, crippled, or other children with specific or serious learning disabilities who require such special or modified physical education and recreation activities to enhance their development.

The Secretary will appoint, from time to time, panels of experts who are competent to evaluate various types of research or demon-

stration projects under this program and secure their advice before making a grant.

The Secretary will appoint a 15-man advisory committee to advise him on matters of general policy relating to the administration of the above programs. Seven members would have to be individuals from the field of physical education, five from the field of recreation, and three will have to be individuals with experience or special interest in the education of mentally retarded or handicapped children.

POLICY STATEMENTS

1. Regarding P. L. 89-749 (Comprehensive Health Planning), there be a state-wide approach to planning rather than regional with the OSMA playing a large role in the state-wide aspect, through the Committee on Government Medical Care Programs.

2. That the OSMA recommend to the agency designee that an advisory committee be appointed to receive applications from local groups, to evaluate them and to establish priorities; this committee to include adequate physician representation appointed from a list supplied by the Ohio State Medical Association.

3. That local planning groups include adequate representation from all county medical societies involved in an individual plan.

4. That the Ohio State Medical Association, county medical societies, and individual physicians contact congressmen from Ohio to request that additional funding for this program

be held up until the Act is changed to reduce or eliminate the potential danger to the practice of medicine and until an adequate role of physicians in the planning is established.

5. With regard to physician's fees, that the OSMA policy regarding the physician's right to bill his patients directly on the basis of his usual and customary fee be maintained in this program.

6. If "centers" or "clinics" are established in connection with this program a "sliding scale" of charges for technical and administrative services be established so that the citizen who may be well able to pay for his health care will be discouraged from using services of the "center."

7. That the operation of Comprehensive Health Planning Services must not infringe upon the private practice of medicine.

Officers and AMA Delegates Elected At the 1967 Annual Meeting

DR. ROBERT E. HOWARD, of Cincinnati, was installed as President of the Ohio State Medical Association at the 1967 Annual Meeting of the Association in Columbus, May 15-19, succeeding Dr. Lawrence C. Meredith, of Oberlin, who will continue to serve on The Council for another year as Immediate Past President.

Dr. Howard is a past president of the Academy of Medicine of Cincinnati and was first named to The Council of OSMA in 1962 as Councilor of the First District. He was named President-Elect at the 1966 Annual Meeting in Cleveland. Dr. Howard is a practicing physician in Cincinnati, specializing in otolaryngology and is on the faculty of the University of Cincinnati College of Medicine. He is certified by the American Board of Otolaryngology.

Dr. Theodore L. Light, Dayton, was named President-Elect, and will assume the office of President at the 1968 Annual Meeting in Cincinnati. Dr. Light is a practicing physician in Dayton, specializing in internal medicine. He is a past president of the Montgomery County Medical Society and served for 14 years as delegate from that Society to the OSMA. He was first elected to The Council in 1963, as Councilor of the Second District. Dr. Light is a delegate of OSMA to the American Medical Association House of Delegates.

Dr. James L. Henry, Grove City, general practitioner, was elected Treasurer of the Association to succeed Dr. Philip B. Hardyman, Columbus, who had served the maximum of two three-year terms in that office. Dr. Henry is a past president of the Academy of Medicine of Columbus and Franklin County and active in various phases of medical organization work.

Elected to succeed Dr. Light as Councilor of the Second District is Dr. George J. Schroer, general practitioner of Sidney.

Dr. James A. Quinn, Jr., of Newark, was elected Councilor of the Eighth District, to succeed Dr. Robert C. Beardsley, Zanesville, who had served the maximum of three terms in that office. Dr. Quinn is director of pathology at the Newark Hospital.

Dr. Oscar W. Clarke, Gallipolis, was elected to fill the remaining year of the unexpired term of Dr. George N. Spears, of Ironton, as Councilor of the Ninth District. Dr. Clarke was appointed by The Council as Ninth District Councilor last September when Dr. Spears resigned for personal reasons.

Councilors re-elected for additional two-year terms are Dr. Robert N. Smith, Toledo, Fourth District; Dr. Edwin R. Westbrook, Warren, Sixth District; and Dr. Richard L. Fulton, Columbus, Tenth District.

Councilors in the midst of two-year terms are Dr. Paul N. Ivins, Hamilton, First District; Dr. Frederick T. Merchant, Marion, Third District; Dr. P. John Robeck, Cleveland, Fifth District; Dr. Sanford Press, Steubenville, Seventh District; and Dr. William R. Schultz, Wooster, Eleventh District.

Dr. Hardyman, alternate delegate to the American Medical Association, was elected to succeed on January 1, 1968, Dr. Edwin H. Artman, Chillicothe, who was not a candidate for re-election. Dr. Meredith was elected alternate delegate to the AMA to fill the post held by Dr. Hardyman.

Dr. Frank H. Mayfield, Cincinnati, Past President of the OSMA, was elected alternate delegate to the AMA, to succeed Dr. J. Robert Hudson, also of Cincinnati, who was not a candidate for re-election.

AMA delegates re-elected are Dr. John H. Budd, Cleveland; Dr. Richard L. Meiling, Columbus; Dr. Frederick P. Osgood, Toledo; and Dr. Charles A. Sebastian, Cincinnati.

Alternate delegates re-elected are Dr. P. John Robeck, Cleveland; Dr. Frank F. A. Rawling, Toledo; and Dr. Robert N. Smith, Toledo.

Because of the time element, only this brief summary of the election is given in this issue. Detailed reports of the Annual Meeting, including minutes of the House of Delegates proceedings, will be published in the July number.

**REPORT ON EXAMINATION OF FINANCIAL STATEMENTS,
YEAR ENDED DECEMBER 31, 1966**

ACCOUNTANTS' REPORT

The Committee on Auditing and Appropriations
Ohio State Medical Association
Columbus, Ohio

We have examined the statement of assets of the Ohio State Medical Association at December 31, 1966, and the related statement of cash receipts and disbursements of the Executive Secretary and the Treasurer and the statement of operations of The Ohio State Medical Journal for the year then ended. Our examination was made in accordance with generally accepted auditing standards and accordingly included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances.

The statements of the Ohio State Medical Journal included herein have been prepared on the accrual basis of accounting. The accounts of the Executive Secretary and the Treasurer included herein have been prepared on the cash receipts and disbursements basis, and, as a result, include as income 1967 membership dues of \$111,065.00. Under generally accepted accounting principles, such dues would be deferred at December 31, 1966 and included in income during 1967. Accordingly, the statements as a whole, do not in our opinion present financial position and results of operations as they would appear had generally accepted accrual basis accounting principles been applied in their preparation.

In our opinion, the accompanying statement of assets at December 31, 1966, and the related statement of cash receipts and disbursements and the statement of operations for the year then ended present fairly the information set forth therein and have been prepared on a basis consistent with that of the preceding year.

Lybrand, Ross Bros. & Montgomery

Columbus, Ohio
March 24, 1967

**OHIO STATE MEDICAL ASSOCIATION
Statement of Assets, December 31, 1966**

	Total	Executive Secretary's Account	Treasurer's Account	The Ohio State Medical Journal
Cash in bank and petty cash	\$220,038.52	\$176,256.95	\$ 41,954.21	\$ 1,827.36
Cash in savings accounts	79,219.20		79,219.20	
Certificates of deposit	20,000.00		20,000.00	
United States Government obligations, at cost	55,000.00		55,000.00	
Accounts receivable — advertisers, less allowance for doubtful accounts of \$74.80	13,399.38			13,399.38
Deposit on postage	160.00			160.00
Office equipment, at cost less accumulated depreciation of \$16,299.29	29,174.64			29,174.64
	<u>\$416,991.74</u>	<u>\$176,256.95</u>	<u>\$196,173.41</u>	<u>\$ 44,561.38</u>

OHIO STATE MEDICAL ASSOCIATION
Statement of Cash Receipts and Disbursements, Year ended December 31, 1966

	Total	Executive Secretary's Account	Treasurer's Account
Cash in bank, beginning of year	\$ 82,131.05	\$ 61,342.63	\$ 20,788.42
Cash receipts:			
1967 Membership dues	111,065.00	111,065.00	
1966 Membership dues	386,280.00	386,280.00	
Interest on cash account and certificates of deposit	8,044.32	7,569.32	475.00
Interest on United States Government obligations	2,142.52		2,142.52
Rent	333.28		333.28
Exhibit space, 1966 annual meeting	17,535.00		17,535.00
Exhibit space, 1967 annual meeting	7,700.00		7,700.00
Fees for collection of A. M. A. dues	3,981.82		3,981.82
Redemption of United States Government obligations	20,000.00		20,000.00
	<u>557,081.94</u>	<u>504,914.32</u>	<u>52,167.62</u>
Interaccount transfers (principally dues)		(390,000.00)	390,000.00
Cash disbursements:			
Ohio State Medical Journal, including \$14,031.90 for furniture and fixtures	61,031.90		61,031.90
Salaries and expenses	135,152.11		135,152.11
Professional conferences and scientific meetings	64,826.91		64,826.91
Committee expenses	12,285.23		12,285.23
Department of Public Relations	24,677.19		24,677.19
Employees' benefits	18,533.07		18,533.07
Contributions	8,981.82		8,981.82
General, including \$20,000 investment in certificates of deposit	95,513.60		95,513.60
	<u>421,001.83</u>		<u>421,001.83</u>
Cash in bank, end of year	\$218,211.16	\$176,256.95	\$ 41,954.21
Cash in savings accounts, beginning of year	\$ 75,869.54		\$ 75,869.54
Interest received	3,349.66		3,349.66
Cash in savings accounts, end of year	\$ 79,219.20		\$ 79,219.20

THE OHIO STATE MEDICAL JOURNAL
Statement of Operations, Year ended December 31, 1966

Income:		
Advertising		\$ 83,491.02
Less:		
Commissions on advertising	\$ 13,095.49	
Cash discount	714.74	13,810.23
Advertising income, net		<u>69,680.79</u>
OSMA appropriation, including \$14,031.90 for furniture and fixtures		61,031.90
Subscriptions		1,189.39
		<u>131,902.08</u>
Expenses:		
Salaries	30,930.00	
Journal printing	68,503.36	
Journal postage	1,435.27	
Stationery, printing, and supplies	4,664.62	
Illustrations and engravings	1,657.08	
Travel expense	20.00	
Depreciation	2,457.27	
Bad debts	74.80	
Miscellaneous postage	407.03	
Loss on disposal of office equipment	6,717.77	116,867.20
Excess of income over expenses		<u>\$ 15,034.88</u>

Angels of Death

FDA Has Become a Threat to U. S. Health and Welfare

Reprinted by Courtesy of Barron's National Business and Financial Weekly
Issue of November, 1966

“LAST April the Food & Drug Administration front-paged an announcement that within the past year there were ‘passed on to the Bureau of Regulatory Compliance a number of complaints involving nearly one-third of the membership of the Pharmaceutical Manufacturers Association.’ A few weeks later FDA announced that ‘last year one-third of the members of the PMA were found to have been in violation of the advertising regulations.’ . . . On September 9, we received a copy of FDA’s list of alleged violators from a representative of the press. If this is the list which was used as the basis for the charges twice leveled against PMA members, and we think it is, we believe the public has been misled. The list indicates that ads involving only nine PMA members—fewer than 5%—were forwarded to the office of the General Counsel during the last two-year period. Of all the ads reviewed, apparently only 89 were even questioned by the medical evaluators. . . . In sum, one-third of an accused PMA membership becomes a lesser fraction. And, within that, lesser infractions. And, among those, a preponderance of allegations, not violations. Isn’t it time to package our government in the truth, along with our cornflakes? Isn’t it fair to require that an agency which demands the truth deliver the truth?”

The recent statements by C. Joseph Stetler, president of PMA, commanded scant attention in the press. Yet it was plainly a remarkable speech. Unlike most spokesmen for regulated industry, who tend to talk softly, Mr. Stetler took a notably hard line. His comments on federal drug regulation bristle with uncompromising quotes like “shabby burst of candor,” and “legislative tripe.” Moreover, the organization which he heads has gone beyond phrasemaking. In early fall, PMA brought suit in U. S. District Court to challenge the FDA’s newly issued rules governing the sale of mineral food supplements and vitamins. Last week Upjohn Co., scoring the agency’s arbitrary behavior, abruptly withdrew all advertising from professional journals. By word and deed alike, the drug companies finally have begun to stand up for their rights.

On Wall Street, which has grown used to swallowing bureaucratic abuse, the news ought to come as

a tonic. It should prove even more welcome to Main Street. Since the ill-conceived Kefauver Amendments to the Food, Drug, and Cosmetics Act were hastily passed four years ago, the industry (and U. S. pharmaceutical progress) have suffered from an excess of regulatory zeal. New drugs coming to market have fallen to the lowest level in a generation. Today, FDA, in the doctrinaire hands of its new Commissioner, Dr. James L. Goddard, has become a clear and present danger to the nation’s health and welfare. The Great Society has never been philosophically sound; now its sickness threatens to spread far and wide.

To judge by a mounting weight of evidence, the ravages already are grave. According to Paul de Haen, Inc., authoritative trade sources, the total number of new drugs put on the nationwide market in 1965 declined to 112, from 157 in 1964. Since the turn of the year, the marketing anemia has grown worse. In the same vein, the number of single chemical entities, far and away the most significant category of new drugs, has fallen from 14 to four. The slump reflects no lack of research effort by the industry. On the contrary, de Haen points out that in the first half of 1966, more than a score of single chemical entities originating in the U. S. were put on sale in Europe. Since 1962, indeed over 3,000 New Drug Applications have been filed with FDA, two-thirds of which are pending. Hence, as of a recent count, the American public has been deprived of Tolonase, a hypoglycemic agent; Quixolin, an anti-diarrheal; Drenisone, a corticoid; and Edocrin, a diuretic for the treatment of edema. New drugs barred from domestic distribution also include a long-acting tranquilizer and a specific for gout. Baxter Laboratories’ Choloixin, which reduces serum cholesterol levels, has been available abroad but not at home, pending FDA approval, for over half-a-decade.

Since the thalidomide tragedy, when an FDA staff member gained fame, in effect, by doing nothing, indecision and delay have become standard operating procedure. Under the regime of Dr. Goddard, authoritarianism and a thinly coated hostility toward the pharmaceutical industry lately have compounded the mischief. Since taking office in January, FDA’s

chief has banned the sale of hundreds of antibiotic cough lozenges as ineffective; removed from the market Hoffmann-LaRoche's Madricidin, a cold remedy, and Ciba's Elipten, an anti-epilepsy drug, on grounds of lack of safety or efficacy; and urged doctors to prescribe "short-acting" sulfonamide compounds. Goddard's rash of forays last Spring elicited a pained response from the head of the American Medical Association: "The manner in which the agency suddenly seizes drugs and accompanies this activity with alarming language tends to create an atmosphere of hysteria. It will inevitably exert a deleterious influence on the effective use of drugs by the physician."

Undeterred, FDA recently has aggravated matters. Besides challenging efficacy or safety, it lately has taken to seizing drug shipments by companies which allegedly fail to meet its advertising standards. The latter, by the way, contain such vague and subjective language as "fair balance," "brief summary" and "relative degree of prominence," terms over which reasonable men might disagree. Dr. Goodard, however, nurses no qualms and brooks no dissent. Alleging that information placed in the Physicians' Desk Reference violated the law, FDA, through the Department of Justice, recently brought criminal actions against Abbott Laboratories, Ciba Pharmaceutical and Upjohn. Last month the agency also seized a shipment of Lincocin, a major antibiotic recently introduced by Upjohn, on charges that an ad in the AMA Journal failed to "fairly show the effectiveness of the drug." Upjohn bitterly protested. "We had no prior notice of specific objections from FDA, even though variations of the ads had been running for many months," declared President R. T. Parfet, Jr. Indeed, Mr. Parfet subsequently learned that FDA took action while he was discussing the matter with Dr. Goddard in the latter's office.

In its proposed restrictions on food supplements and vitamins, finally, FDA has launched an assault on the scientific method. For example, the agency proposes that all packages carry the following legend: "Vitamins and minerals are supplied in abundant amounts by the foods we eat. The food and nutrition board of the National Research Council recommends that dietary needs be satisfied by foods." This statement, retorted Dr. W. H. Sebrell, Jr., chairman of the National Academy of Sciences-National Research Council committee on recommended dietary allowances, "is objectionable, misleading and . . . creates a false impression." Dr. Sebrell went on to accuse FDA of widespread distortion of his committee's report. Fortified by the support of the scientific community, the Pharmaceutical Manufacturers Association, as noted, has taken its case to court. By resisting what it flatly labels "pharmaceutical dictatorship," PMA also has struck a blow in behalf of the public's well-being.

What the nation already owes the drug makers can never be repaid. According to a study by Arthur D.

Little, Inc., the decline in the death rate since 1935 has allowed over four million people of working age to survive. Two million would have fallen victim to just four diseases—tuberculosis, syphilis, influenza and pneumonia. Viewed in this light, the medicine men of FDA, all unwittingly perhaps, are angels of death. The 90th Congress should clip their wings.

Do You Know? . . .

Dr. A. H. Kyriakides, Akron, Summit County coroner, was named president of the Ohio State Coroners' Association at the organization's annual convention in Cincinnati. Dr. Frank P. Cleveland, Cincinnati, is the new vice-president, and Dr. Samuel Gerber, Cuyahoga County, is secretary-treasurer.

* * *

Dr. Vinton E. Siler, professor of surgery at the University of Cincinnati Medical Center, will be at the helm of the American Society for Surgery of the Hand during 1968. He is president-elect this year. Dr. Siler established a Hand Clinic at Cincinnati General Hospital, in the University of Cincinnati Medical Center, considered the second oldest in the nation in a large metropolitan hospital.

* * *

Dr. Richard L. Meiling, Columbus, was principal speaker for the first annual Aerospace Medical Research Laboratories awards dinner held at the Wright-Patterson Officers' Club. Dr. Meiling is dean of the College of Medicine, Ohio State University, and is a major general in the Reserve Medical Service of the U. S. Air Force.

* * *

Dr. Charles H. Herndon, Cleveland, has been named president-elect of the American Academy of Orthopaedic Surgeons. He is professor of orthopaedic surgery at Western Reserve University and heads the Division of Orthopaedic Surgery at University Hospitals.

* * *

Dr. Roland Fischer, associate professor of psychiatry in the Ohio State University College of Medicine, is consulting editor for a monograph on the "Interdisciplinary Perspectives of Time" published by the New York Academy of Sciences.

* * *

Dr. Frank H. Mayfield was elected president of the Society of Neurological Surgeons for the 1967-1968 term at that organization's annual meeting in Portland, Oregon.

Ad Astra

John Loveless Beach, M.D., St. Petersburg, Florida; Western Reserve University School of Medicine, 1916; aged 77; died March 23; member of the Ohio State Medical Association and the American Medical Association. The third generation of physicians to serve the Medina County area, Dr. Beach was a practitioner of long standing in Seville. He retired in 1949 and moved to Florida. Affiliations included memberships in the Methodist Church and the Masonic Lodge. Survivors include his widow, a daughter, and a son.

Malcolm Eugene Boylan, M.D., Sandusky and Milan; Harvard Medical School, 1929; aged 62; died February 1; member of the Ohio State Medical Association and the American Medical Association. Dr. Boylan was physician for the New Departure Division of General Motors Corporation in Sandusky.

Charles Alexander Broadbus, M.D., Carmel, Calif.; Western Reserve University School of Medicine, 1910; aged 87; died December 10. Dr. Broadbus specialized in otolaryngology in his practice in California.

Eldred Leon Clem, M.D., Ashland; Western Reserve University School of Medicine, 1924; aged 67; died April 3; member of the Ohio State Medical Association, the American Medical Association, and the American Academy of General Practice. Dr. Clem's practice in Ashland extended over a period of more than 40 years. He was active in numerous community affairs; was past president of the Rotary Club, a member of the Christian Church, a member of the American Legion, and a captain in the Ohio National Guard. Survivors include his widow, two daughters, one of whom is Dr. Vera Chalfant of Ashland; a son and two sisters.

Paul Stanley Curran, M.D., Cleveland Heights; St. Louis University School of Medicine, 1921; aged 70; died April 7; member of the Ohio State Medical Association and the American Medical Association. A physician of long standing in the Greater Cleveland area, Dr. Curran retired in 1964. Three sons are professional men; Dr. John P., Cleveland physician; Dr. Robert M., Columbus physician; and Dr. James P., Cleveland dentist; also surviving are his widow, three other sons and three daughters. Final rites were from the St. Ann Catholic Church.

Richard Leroy Gilson, M.D., Napoleon; Ohio State University College of Medicine, 1942; aged 52; died April 26; recent member of Ohio State Medi-

cal Association and the American Medical Association. Dr. Gilson opened his practice in Napoleon after completing his internship at Maumee Valley Hospital, Toledo. He was active in numerous community affairs; was physician for the high school band and athletic teams, and for the National Guard unit. He was a member of the Presbyterian Church, the Odd Fellows Lodge, Fraternal Order of Police, and the Masonic Lodge. A son and a daughter survive.

Edward John Glaser, M.D., Cincinnati; Stritch School of Medicine of Loyola University, 1945; aged 47; died January 5; member of the Ohio State Medical Association, and recent member of the American Medical Association; Fellow of the American College of Surgeons. Dr. Glaser's practice in Cincinnati was in the field of ophthalmology. He was a veteran of World War II.

Phillips Foster Greene, M.D., New Richmond; Harvard Medical School, 1919; aged 74; died April 11; member of the Ohio State Medical Association and the American Medical Association; Fellow of the American College of Surgeons. Dr. Greene settled in New Richmond about eight years ago and continued a distinguished career. After service in the Medical Corps during World War I, he went to China in 1923 under the Yale-in-China medical program to train medical students. He stayed in the Orient 20 years, returning to his country after the Communist threat to take over in China. After several years as associate dean of the Long Island College of Medicine, he returned to the Orient and set up an orthopedics service in the hospital in Burma under the Point Four program. In Clermont County, he was active in the Clermont dental clinic, the well child clinic, the tuberculosis society, the cancer program, Community Action Commission, the Health and Welfare Council, historical groups, and he was treasurer of the Clermont County Medical Society. Survivors are his widow, a son, two daughters, and three brothers.

Abraham E. Hoodin, M.D., Niles; University of Cincinnati College of Medicine, 1933; aged 57; died April 30; member of the Ohio State Medical Association, the American Medical Association, and the American Academy of General Practice. Dr. Hoodin moved to Niles in 1941, then served from 1942 to 1945 in the Army Medical Corps, and returned to Niles after a short tour with the Public Health Service. In addition to his private practice, he was local health commissioner. Among affiliations he was a

member of the Temple, the American Legion and the Masonic Lodge. Survivors include his widow, four sons, a daughter, and two sisters.

Corliss R. Keller, M. D., Hamilton; Miami Medical College, Cincinnati, 1906; aged 82; died April 15; member of the Ohio State Medical Association and the American Medical Association; Fellow of the American College of Physicians. A native of Hamilton, Dr. Keller devoted his entire professional lifetime to practice in that vicinity. He was active in the affairs of the local Academy of Medicine and in 1965 was voted a lifetime membership in the society. Among survivors are his widow and three daughters.

George Lincoln King, M. D., Alliance; University of Pennsylvania School of Medicine, 1926; aged 67; died April 26; member of the Ohio State Medical Association, the American Medical Association, and the American Academy of Ophthalmology and Otolaryngology. An earlier resident of Alliance, Dr. King, after his medical training, returned there to practice in association with his father, the late Dr. George L. King, Sr. His specialty was ophthalmology, and he was associated with a group of doctors, including his brother Dr. Douglas S. King, and a nephew, Dr. Christopher M. King. For 18 years he was president of the board of Mount Union College and in 1954 was awarded an honorary doctor of laws degree by the college. He was a member of the Methodist Church, a past president of the Kiwanis Club, and active in numerous other community affairs. Surviving are his widow, two sons, a daughter, his brother, and a sister.

Alec Cameron MacNiel, M. D., Cleveland; University of Toronto Faculty of Medicine, 1927; aged 66; died May 2; member of the Ohio State Medical Association, the American Medical Association, and American Thoracic Society; Fellow of the American College of Physicians; diplomate of the American Board of Internal Medicine. Dr. MacNiel was in private practice in Cleveland, specializing in internal medicine, from 1946 until he retired in 1961. Earlier he took internship and residency training in Cleveland and was on the faculty of Western Reserve University School of Medicine. Surviving are his widow, a son, and two sisters.

Paul Arthur Paulson, M. D., Massillon; Rush Medical College, 1919; aged 76; died April 26; member of the Ohio State Medical Association, and recent member of the American Medical Association. Dr. Paulson devoted his professional lifetime to practice in the Massillon and Canal Fulton areas of Stark County. Among affiliations, he was a member of several Masonic bodies and the Lutheran Church. Survivors include his widow and three sons.

Hans Friedrich Plaut, M. D., Dayton; Faculty of Medicine, University of Leipzig, 1922; aged 70; died

April 6; former member of the Ohio State Medical Association and the American Medical Association; member of the American Roentgen Ray Society and the Radiological Society of North America; diplomate of the American Board of Radiology. Dr. Plaut was associated with the Brown Hospital at the Veterans Administration Center in Dayton, where he specialized in radiology. Survivors include his widow, two sons, a daughter, and a brother.

George Wilmer Pugh, M. D., Dayton; Meharry Medical College, 1917; aged 78; died April 19. A practitioner in Dayton for some 40 years, Dr. Pugh was active in affairs of the National Medical Association and for many years was a delegate to that organization. He was a member of the Baptist Church and several fraternal orders. Surviving are a son and a sister.

Bernard A. Schwartz, M. D., Cincinnati; University of Cincinnati College of Medicine, 1924; aged 69; died April 8; member of the Ohio State Medical Association, the American Medical Association, and the American College of Cardiology. A Cincinnati cardiologist of long standing, Dr. Schwartz was active in all phases of heart association work, and was twice president of the Ohio State Heart Association. After retiring from active practice last November, he continued to serve the Max and Martha S. Stern Heart Station which he helped to found. He was a member of the Temple. Surviving are two sons, two brothers, and a sister.

George James Searle, Jr., M. D., Plymouth and Mansfield; Ohio State University College of Medicine, 1922; aged 69; died April 6; member of the Ohio State Medical Association, the American Medical Association, the American Academy of General Practice, American Society of Abdominal Surgeons; Fellow of the International College of Surgeons. Dr. Searle began his practice in Plymouth in association with his father, the late Dr. George J. Searle, Sr., and later opened an office in Mansfield where he took active part in professional work. He was a member of the Episcopal Church, the Sons of the American Revolution, and several Masonic bodies. Surviving are his widow, a daughter, and a step-sister.

Maurice E. Scheetz, M. D., Lima; Eclectic Medical College, Cincinnati, 1936; aged 58; died April 8; member of the Ohio State Medical Association, the American Medical Association, and the American Academy of General Practice. A practitioner of some 30 years standing in Lima, Dr. Scheetz took time out for a military tour during World War II, and another during the Korean Conflict. He was a member of the Veterans of Foreign Wars. Other affiliations included membership in several Masonic bodies and the Presbyterian Church. He is survived by his widow, a son, and a brother.

Edith Smith, M. D., Lexington, Ky.; Medical College of Ohio, Cincinnati, 1909; aged 91; died De-

cember 19; former member of the Ohio State Medical Association. Dr. Smith was a former practitioner and long a resident of Cincinnati. She was last a member of the State Association in 1939.

Lester W. Stacey, M. D., Cincinnati; Medical College of Ohio, Cincinnati, 1905; aged 84; died April 17; member of the Ohio State Medical Association and the American Medical Association. A native of the Cincinnati area, Dr. Stacey established his office in Norwood in 1907 and continued in practice there until his retirement in 1953. He was a member of the Masonic Lodge. Surviving are his widow, a son, a sister, and a brother.

V. Leslie Tichy, M. D., Cleveland; Western Reserve University School of Medicine, 1931; aged 67; died April 11; former member of the Ohio State Medical Association and the American Medical Association; Fellow of the American College of Surgeons; diplomate of the American Board of Surgery. A practitioner of long standing in Cleveland, Dr. Tichy specialized in surgery.

Frank C. Yeager, M. D., Dover; Creighton University School of Medicine, 1930; aged 77; died April 6, member of the Ohio State Medical Association and the American Medical Association. Dr. Yeager's practice in the Dover area extended back some 25 years. Earlier he was in Lakewood. Survivors include his widow and a son.

Earl Benjamin Zurbrugg, M. D., Zanesville; Washington University School of Medicine, 1933; aged 62; died April 10; member of the Ohio State Medical Association and the American Medical Association. Dr. Zurbrugg established his Zanesville office in 1937 for general practice, and in 1952 limited his practice to anesthesiology. He is survived by his widow, three sons, a daughter, a sister, and two brothers.

New Members . . .

Following are names of new members of the Ohio State Medical Association certified to the headquarters office during April. List shows name of physician, county, and city in which he is practicing, or in which he is taking postgraduate work.

Allen

William R. Hanna, Lima

Athens

Elizabeth C. Hoover, Athens
Leland P. Randles, Athens

Cuyahoga

Jorge P. Alonso, Cleveland
Michael A. Balourdass, Cleveland
Donald P. Becker, Cleveland
I. John Davies, Cleveland
Remigio J. Flor, Cleveland
Virginia G. Ingram, Cleveland
Josif Kondovski, Cleveland
Manuel Posso, Cleveland
Donald A. Schutt, Cleveland
Carlos J. Torrent, Cleveland
Mauro S. Tuason, Cleveland
Manuel D. Valera, Cleveland
George B. Vassilakis, Cleveland

Franklin

Paul F. Bonnici, Columbus
J. Richard Briggs, Columbus
Robert F. Burns, Columbus
Robert F. Chosy, Worthington
Csaba F. Csetri, Columbus
Lionel E. Dorfman, Columbus
James W. Kilman, Columbus
John A. Klamar, Columbus
William V. Nick, Columbus
Charles E. Reier, Columbus
Cecil M. Thorne, Columbus
James W. Webb, Reynoldsburg

Gallia

Edward M. Spencer, Gallipolis

Hamilton

Donald L. Bebensee, Cincinnati
Larry W. Best, Cincinnati
Elbert H. Brown, Cincinnati
Victor N. Ivanov, New York
H. Paul Lewis, Cincinnati
Norda R. Serrano, Cincinnati
Generosa A. Simon, Cincinnati

Jackson

Manuel M. Pezeshki, Oak Hill

Jefferson

Milford M. Milic, Steubenville

Lake

Nicholas T. Pelecanos, Wickliffe

Lucas

Glidden L. Brooks, Toledo
James G. Diller, Toledo
Nonito M. Sablay, Toledo
Marvin Weisbard, Cincinnati

Montgomery

Alan Tropauer, Dayton

Seneca

Roberto R. Pagarigan, Tiffin

Summit

Robert C. Burns, Akron
Alfredo V. Casino, Barberton
Alois Rebec, Barberton

Trumbull

Roger R. Lewis, Warren

Dr. Joseph A. Bonta, Columbus, vice-president of the Ohio Division of the American Cancer Society, was speaker at a session of the Ohio Federation of Women's Club, where he discussed the theme, "Conquer Uterine Cancer."



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Activities of County Societies...

First District

(COUNCILOR: PAUL N. IVINS, M. D., HAMILTON)

CLINTON

Dr. Richard De Wall, Dayton, spoke on the subject of open heart surgery at the April 25 meeting of the Clinton County Medical Society. The illustrated presentation was given at the Clinton Memorial Hospital in Wilmington.

HAMILTON

An "International Symposium on Colonic Polyps and Cancer" was held on April 18 under joint sponsorship of the Academy of Medicine of Cincinnati, American Cancer Society, Cincinnati and Hamilton County Chapters, and the Cincinnati Surgical Society.

The following persons were on the panel: Sir Clifford Naunton Morgan, London, England; Mr. E. S. R. Hughes, Melbourne, Victoria, Australia; Jack Cole, M. D., professor and chairman of the Department of Surgery, Yale Medical School; Lauren V. Ackerman, M. D., professor of surgical pathology, Washington University; and William A. Altemeier, M. D., director of the Department of Surgery, University of Cincinnati College of Medicine.

Numerous specialty societies of the Cincinnati area held meetings and presented programs during recent weeks.

Second District

(COUNCILOR: GEORGE J. SCHROER, M. D., SIDNEY)

MIAMI

Dr. Richard DeWall, Dayton, discussed "Open Heart Surgery," at the April meeting of the Miami County Medical Society. The dinner meeting was held at the Troy Country Club.

Physicians and attorneys met together for the May 2 dinner session of the Miami County Medical Society held at the Piqua Country Club. Russell H. Volkema, attorney, was the speaker.

Third District

(COUNCILOR: FREDERICK T. MERCHANT, M. D., MARION)

ALLEN

Dr. Robert Izant, Jr., assistant professor of pediatric surgery at Western Reserve University School of Medicine, discussed "Abdominal Tumors in Children," at the April dinner meeting of the Academy

of Medicine of Lima and Allen County, and the Lima Academy of General Practice.

HARDIN

Dr. Lionel E. Dorfman, of the Division of Urology at Ohio State University College of Medicine, Columbus, spoke before the April meeting of the Hardin County Medical Society in Kenton, on the diagnosis and treatment of common urinary tract infections.

Fourth District

(COUNCILOR: ROBERT N. SMITH, M. D., TOLEDO)

LUCAS

Members of the Academy of Medicine of Toledo and Lucas County met on May 12 for a program sponsored by the Toledo Obstetric and Gynecological Society.

Dr. Thomas N. Evans, professor of obstetrics and gynecology, Wayne State University, spoke on "The Use of Globulins in Iso-immunization."

The Surgical Section had as speaker on May 26 Dr. Charles G. Child, III, professor of surgery, University of Michigan. His topic was "Upper Gastrointestinal Hemorrhage."

Fifth District

(COUNCILOR: P. JOHN ROBECHER, M. D., CLEVELAND)

CUYAHOGA

The William E. Lower Lecture was presented by the Academy of Medicine of Cleveland and the Cuyahoga County Medical Society on May 3. A social hour and dinner preceded the evening program.

Speaker for the occasion was Dr. Denton A. Cooley, chief of cardiac surgery, Baylor University, whose topic was "Cardiac Surgery—Past, Present, Future."

The Whitacre Lecture, sponsored by the Cleveland Society of Anesthesiology and the Academy of Medicine, was given following a dinner meeting in the Sheraton-Cleveland Hotel. The topic "High on Hypoxia Hill" was discussed by Dr. Thomas E. Hornbein, assistant professor of anesthesiology, University of Washington.

MAHONING

Speaker at the April 18 meeting of the Mahoning County Medical Society was Dr. Paul W. Gikas, associate professor, Department of Pathology, University of Michigan. He spoke on "Pathogenesis of



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Contraindications: Barbiturates should not be administered to anyone with a history of porphyria, nor should they be given in the presence of uncontrolled pain, because excitement may result.

Warning: May be habit-forming.

Precautions: Tuinal should be used cautiously in pa-

tients with decreased liver function, since prolongation of effect may occur.

Adverse Reactions: Idiosyncrasy, such as excitement, hangover, or pain, may appear. Hypersensitivity reactions occur in some patients, especially in those with asthma, urticaria, or angioneurotic edema.



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Fatal Injuries in Automobile Accidents." Dr. Gikas was introduced by Dr. Elias T. Saadi, program chairman. Dr. Harold J. Reese, president, presided.

* * *

The Mahoning County Medical Society conducted a measles campaign during the month of April, culminating in Measles Week, April 23-28. A total of 4,340 children were immunized during the final week. No record is available of the total immunized during the first three weeks. Parents were encouraged to take their children to their physicians for immunizations. During the final week, the facilities of existing department of health clinics were used. The measles committee consisted of Dr. Kurt Wegner, chairman, Dr. H. P. McGregor, Dr. R. A. Wiltsie and Dr. S. F. Petraglia.

Sixth District

(COUNCILOR: EDWIN R. WESTBROOK, M. D., WARREN)

SUMMIT

"The Human Factor in Space Engineering" was the subject discussed at the May 2 meeting of the Summit County Medical Society, held in the Children Hospital, Akron. Speaker was Dr. Julian M. Christensen, Wright-Patterson Air Force Base, Dayton.

TRUMBULL

Dr. Ray W. Gifford, Jr., was speaker for the April meeting of the Trumbull County Medical Society at the Trumbull Country Club. He is a member of the Department of Hypertension and Renal Diseases of the Cleveland Clinic and made his presentation within his specialty field.

Dr. Allan L. Schaffer, president of the Society, presided and conducted the business part of the meeting.

Seventh District

(COUNCILOR: SANFORD PRESS, M. D., STEUBENVILLE)

BELMONT

Dr. David Gillespie, Cleveland, was speaker for the April 20 meeting of the Belmont County Medical Society. Dr. Gillespie is director of pulmonary disease services at Cleveland Metropolitan Hospital, and used as his topic "Evaluation of Breathlessness and Respiratory Impairment."

Dr. Gillespie's appearance was in keeping with the Society's policy of inviting natives of Belmont County to speak during 1967. He is a native of Barnesville.

Tenth District

(COUNCILOR: RICHARD L. FULTON, M. D., COLUMBUS)

PICKAWAY

Dr. Alvin M. Mauer, member of the staff of Children's Hospital in Cincinnati, was guest speaker for the April meeting of the Pickaway County Medical Society in Circleville. His topic was "Bleeding Disorders in Children."

Eleventh District

(COUNCILOR: WILLIAM R. SCHULTZ, M. D., WOOSTER)

LORAIN

The Twentieth Annual Medical Symposium of Lorain County Medical Society was held on April 12, at Oberlin Inn. Commencing at 2:00 P. M., the theme of the Symposium, sponsored by the Education and Symposium Committee under the chairmanship of I. M. Suna, M. D., was "Current Trends in Acute Care."

Several physicians from other counties within the Eleventh District, and members of the Lorain County Osteopathic Association joined the Medical Society membership for this educational opportunity, and residents and interns of Elyria Memorial Hospital and Lorain St. Joseph Hospital were invited as guests of the Medical Society.

David Allen, M. D., director of anesthesiology at Children's Memorial Hospital, Chicago, lectured on "Intensive Care of Children with Special Reference to the Infant." L. S. Bushnell, M. D., assistant in anesthesiology, Massachusetts General Hospital, Boston, chose as his topic "Management of Respiratory Problems in a Surgical Intensive Care Unit" and F. S. Cross, M. D., director of surgery, St. Luke's Hospital, Cleveland, spoke on "Intensive Care of the Post-Operative Surgical Patient." "Intensive Coronary Care in 1967" was presented by Clyde D. Schoenfeld, M. D., assistant professor, Division of Cardiology, Ohio State University College of Medicine.

Following the social hour and dinner, the Symposium concluded with the evening session presented as an "Open Panel Discussion" between the audience and the afternoon participants. President R. S. Van Dervort, M. D., extended a cordial vote of thanks to the Panel for such an excellent presentation. The Medical Society membership heard a brief progress report of the planning towards the "End Measles" Clinic to be scheduled for Sunday, May 21.

Dr. Wallace B. Hamby, head of the neurological staff at the Cleveland Clinic Foundation, is one of five persons selected to receive the distinguished service citation of the University of Oklahoma.

Dr. Jerome Gross, Cleveland, physician and amateur violinist, was selected to receive the first annual Citizenship Award of the Cleveland Elementary Principal's Association.

Dr. Harvey Gunderson spoke on the subject of hearing difficulties at the fifth annual workshop for senior citizen club leaders held at the Toledo Academy of Medicine building.

Dr. John Cahill, of Willoughby, discussed "the pill" at a meeting of the Junior Women's Club of Mentor.

Woman's Auxiliary Highlights...

By MRS. S. L. MELTZER, Chairman, Publicity Committee

2442 Dorman Drive, Portsmouth 45662

IT WAS Lord Byron who wrote "Behold our home! These are our realms, no limit to their sway. . . ." I didn't intend to wax poetic, but those lines came to mind as I started to write this column and dedicate the lead to Ohio Auxiliary's first real "home" at 4075B North High Street, Columbus.

Space, consisting of the entire ground floor (700 square feet no less!) is being rented in the Ohio Academy of General Practice building. We have our own private entrance, an ample parking lot and an easily accessible office. The building in which our Auxiliary headquarters is now housed is a beautiful modern structure. The Academy of General Practice has been most cooperative, lending us chairs and large work tables and placing at our disposal its Board Room and kitchenette facilities.

Mrs. Lucille Egger is the Auxiliary's new secretary. Serving on what is called the Office Committee are Mrs. James Wychgel, chairman; Mrs. Christopher Colombi, cochairman, and Mrs. Duane Banks, secretary-treasurer. Mrs. Florence Landis who is executive secretary of the Ohio Academy of General Practice, has been assisting with the physical set-up and facilities. The new Central Office is open on Tuesday, Wednesday, and Thursday of each week from 9:00 A. M. to 2:00 P. M. Mrs. Landis has generously offered to cover our telephone when the Auxiliary office is not open. Recent purchases for our "home" have included files, a desk, posture chair, an electric typewriter and a credenza for a mimeograph machine and supplies.

With a membership of 5,370, Ohio's Auxiliary has well-earned for itself a place to call its own.

It is certainly worth noting that the Cuyahoga County group has given a \$25 gift to the Central Office fund to buy some needed item for the new headquarters. It's the first such gift—but I'm sure the committee is hoping that it's not the last! Don't you agree that it would be a mighty nice (and practical!) idea for each county auxiliary to give a monetary gift compatible with the state of its finances? Mind you, I'm not hinting (at least not much!).

National Convention

By the time this appears in print, it will be close to "starting time" for the forty-fourth annual convention of the Woman's Auxiliary to the American Medical Association. The specific dates are from

June 18 through June 22. Atlantic City, in case you don't know. At the Hotel Shelburne, ditto . . .

There will be a three-day program combining the area's seaside and boardwalk activities with historic sightseeing that will be made available for physicians' children during the convention. On Monday, June 19, pre-teens and teens will participate in an all-day boat trip and boardwalk jaunt. This includes a 1½ hour voyage around Atlantic City; lunch; tour of a salt water taffy factory (can't grown-ups come too??); visit to Tussaud Wax Museum and a choice of pool or ocean swimming, ice-skating or a tour of the National Aviation Experimental Center.

Tuesday's program covers an island excursion with sports, games, speedboat rides, water skiing, aquaplaning (with parental permission) and a picnic. Following a rolling chair ride on the boardwalk, the two groups will tour the Towne (sic) of Smithville, historic restoration village. Monday and Tuesday must be taken as a combined package tour. Total cost for one child, including lunches and transportation, is \$23. For two or more children in one family, the price is \$21 each.

A choice of two daytime tours is offered Wednesday, June 21. The first, a visit to Philadelphia, includes Independence Hall, Betsy Ross House, Christ Church and Franklin Institute, with push-button exhibits covering aviation, science and astronomy. Time permitting, a trip will be made to Commodore Dewey's flagship, the *U.S.S. Olympia*. The alternate tour covers highlights of Atlantic City, such as Absecon Lighthouse, then on to Batsto, a restored Revolutionary War iron town with its grist mill and old forge. A stage coach ride and swimming party wind up the day. Total price for each of the Wednesday events is \$11.50 for one child or \$10 each for two or more children in the same family.

A special evening party will be held Tuesday, June 20. Teens will have dinner before going to the Million Dollar Pier for rides, followed by either a bowling tournament or a movie. Price is \$12.50. For those in the 6 to 12 age bracket, plans have been made for dinner, games, rides on the boardwalk, and a movie, at a cost of \$11.50. The special children's activities' program is again being handled by Gulliver's Trails, Inc.

Around Ohio

At the April meeting of the Knox County Medical Society (to which Auxiliary members were invited), Dr. Robert E. Sooy presented an exciting, informa-

tive talk on Project Viet Nam. Dr. Sooy had recently returned from South Vietnam where he was stationed in DaNang as a member of a U. S. Public Health Team providing medical care for the sick and wounded in the DaNang Civil Hospital.

Dr. Sooy told of his experiences in caring for the people in this war-torn country (the slides he showed added to the vividness of his story). He indicated that the Vietnamese seem to thrive on neglect and for the past one thousand years they have had little in the way of medical care. The DaNang Civil Hospital has approximately 500 beds and the patient load varies from 700 to 800 patients. This means of course, Dr. Sooy pointed out, that oftentimes two or more patients are confined in the same bed. Such ancient diseases as plague, cholera and typhoid fever were seen, as were many surgical problems which included small firearm wounds to the abdomen and chest. Also seen were burns and wounds resulting from mortar and mine explosions.

Mrs. Sooy accompanied her husband to the meeting. She was dressed in a beautiful aqua and white Audai (pronounced owjai), a typical Vietnamese attire which is a skin tight outer garment, floor length, slit from waist to knee, under which is worn white pantaloons, all made of silk. On her feet were the Vietnamese high-heeled platform sandals beautifully painted with floral designs. Following Dr. Sooy's talk, the auxiliary served refreshments.

"Caribbean Cruise"

Lucas County members who attended the AMA-ERF bridge luncheon on April 11 enjoyed all the excitement of a Caribbean Cruise. The tables were fittingly and attractively decorated as cruise ship tables and they groaned under the weight of the many unusual Caribbean dishes that were tempting and delicious and (so I'm told) lacking in calories!! Lucas County's publicity chairman, Mrs. Gerald Stark, commented that "more interesting than all the sights were the beautifully clad women aboard" The Cruise Committee included Mrs. Brian Bradford, chairman; Mrs. Jack Burnheimer, cochairman; Mrs. John Gibbs, Mrs. Orrin Keller, Mrs. Charles Tittle, Mrs. Gordon Todd and Mrs. Robert Walker.

"Sweeter than lollipops" describes the volunteers at the Citizens' Day Care Centers and just as sweet are the grateful recipients of this program. Children from the East Toledo Neighborhood House and the Bell Ringer Chorus from Westfield School, performed at the Citizens' Day Care luncheon, honoring volunteers. Exquisite crowns of spring flowers were made by the children of the Miami Children's Home and presented to the volunteers. Lollipops emphasized the theme of the day and were beautifully and cleverly used as decorations. Mrs. James M. Diethelm served as auxiliary chairman, with Mrs. John J. Tansey as cochairman.

Lucas auxiliary's annual meeting was held on May 9 at the Sylvania Country Club. The luncheon com-

mittee was under the leadership of Mrs. Daniel Sullivan and Mrs. Thomas Geraciotti. Mrs. Howard Smith was installed as the new president.

The Allen County Auxiliary concluded its year on April 18 with a covered dish luncheon and installation of officers in the home of Mrs. Vernon A. Noble. Mrs. Karl Ritter, president-elect of the National Auxiliary, installed Mrs. L. W. Like, president; Mrs. Dwight L. Becker, president-elect; Mrs. Robert Zarzar, vice-president; Mrs. Robert Holladay, secretary; Mrs. Thomas Leech, treasurer.

Mrs. Martin Sondheimer received the community service award for her civic contributions. The Rural Health and Safety committees presented a style show of funny hats depicting household hazards and safety measures to prevent them. Members of the hostess committee included: Mrs. Frederick D. Rhodes, chairman; Mrs. Maurice Lewis, Mrs. Joseph Oppenheim, Mrs. Ralph Snowball, Mrs. David Steiner, Mrs. Robert Doernberg, Mrs. Donald English, Mrs. Bernard Glass and Mrs. Holladay.

May Breakfast

Scioto County's traditional May Breakfast was held, as it has been for many years, at the home of Mrs. H. M. Keil, one of those special kind of hostesses. Places were laid for 40 members at what is undoubtedly one of the favorite meetings of the year. Installation of officers is an important ceremonial of this rather unusual morning meeting (the breakfast itself is like something out of the Waldorf!) Mrs. Samuel L. Meltzer, state publicity chairman, installed the new officers who included: Mrs. Clyde Hurst, president; Mrs. William Daehler, president-elect; Mrs. Jerome Rini, vice-president; Mrs. Richard Villarreal, secretary; Mrs. Donald Appleton, treasurer; Mrs. James Scott, historian; Mrs. Frank Gatti and Mrs. Harlan Williams, elected members to the Board.

Committee chairmen presented their annual reports, as did the outgoing officers. It was announced that \$1,063.00 had been raised for AMA-ERF. Mrs. Williams is the retiring president.

It was a big night in Tuscarawas County on April 5, when Dr. Edward Annis of Miami, Florida, and a past president of the AMA, lashed out against the federal Medicare program before some 350 persons in the Dover High School Auditorium. The program was sponsored by the local auxiliary. Dr. Annis issued the challenge to "preserve the spirit of volunteerism in American medicine and provide help to those who need it." Criticizing the "bureaucracy, red tape, delay and cost" of the program, the eminent physician stated that he feared the volunteerism and individual and local efforts which have sparked great medical progress in the past would be lessened in upcoming generations. When one member of the audience, apparently a doctor, said "Why don't we go on strike?" The politicians know this and

use this on us." Dr. Annis' appearance was made possible through the efforts of Dr. and Mrs. E. L. Miller of Dennison.

Members of the Washington County auxiliary toured the Fenton Art Glass Company recently. Following the tour, dessert was served at the home of Mrs. Archbold Jones, Jr. Mrs. Richard Hille, president, conducted the business session. Mrs. George Bateman, chairman of the nominating committee, announced the slate of officers which was then voted upon. New officers for the coming year will be: Mrs. T. P. O'Maille, president; Mrs. James Hoy, president-elect; Mrs. Richard Sloan, vice-president; Mrs. Robert Rudolph, treasurer; Mrs. Tom D. Halliday, secretary.

Publicity Chairman!

It would help considerably if, when you are sending in names of officers, chairmen, etc., you would, please, do it thus: (by way of example) Mrs. John Jones, rather than Mrs. Mary Jones. Also, I'd appreciate knowing the specific date of the event sent in. Even the majority of newspaper clippings sent me lack the dateline. One last request: If you send in typewritten accounts, may I have detailed information? Thanks a million!

Cincinnati College of Medicine Receives Substantial Gift

The Department of Surgery of the University of Cincinnati College of Medicine has received a pledge of \$100,000 to be contributed by Mr. and Mrs. J. Ralph Corbett. A substantial amount of this contribution has already been received by the University. These funds will go toward the construction of a new surgical research unit — for the specific purpose of cancer research.

Dr. William A. Altemeier, chairman, Department of Surgery, noted that among numerous donors to the unit have been members of the surgical faculty and many surgeons throughout the United States who received their training as residents in UC's Department of Surgery. The Corbett gift is second in size only to the bequest of \$360,000 received from the late Charles H. Deppe.

Dr. Altemeier emphasized that the new surgical research unit is urgently needed to provide space and facilities for expanded research in cancer, heart and vascular diseases, surgical infections, shock, wound healing, burns, surgical physiology, and organ transplantation. The Corbett gift is for cancer research. Construction is planned to begin in May or June, 1968.

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COUNTY SOCIETIES' OFFICERS AND MEETING DATES

First District

Councilor: Paul N. Ivins, Hamilton 45011
306 High Street

- ADAMS—Gary J. Greenlee, President, Farmers' National Bank Building, Manchester 45144; Hazel L. Sproull, Secretary, P.O. Box 337, West Union 45693.
- BROWN—A. A. Gruber, President, 320 West Plane Street, Bethel 45106; John R. Donohoo, Secretary, 111 West Cherry Street, Georgetown 45121.
- BUTLER—Brady Randolph, President, 128 North Front Street, Hamilton 45011; Mr. Charles G. Greig, Executive Secretary, 110 North Third Street, Hamilton 45011. 3rd Wednesday monthly.
- CLERMONT—Noco Capurro, President, 481 Craig Road, Cincinnati 45244; Albert W. Van Sickle, Secretary, Box 365, Batavia 45103. 3rd Wednesday monthly except July, August and December.
- CLINTON—H. Richard Bath, President, 290 West Main Street, Wilmington 45177; Mary R. Boyd, Secretary, Box 629, Wilmington 45177. 4th Tuesday monthly.
- HAMILTON—Elmer R. Maurer, President, 3942 North Cliff Lane, Cincinnati 45220; Mr. Edward F. Willenborg, Executive Secretary, 320 Broadway, Cincinnati 45202. 3rd Tuesday monthly.
- HIGHLAND—Thomas L. Jones, President, 528 South Street, Greenfield 45123; Glenn B. Doan, Secretary, 614 Jefferson Street, Greenfield 45123.
- WARREN—George A. Rourke, President, 210 Mound Street, Lebanon 45036; Ray E. Simindinger, Secretary, 901 North Broadway Street, Lebanon 45036. 2nd Tuesday monthly.

Second District

Councilor: George J. Schroer, Sidney 45367
322 Second Ave.

- CHAMPAIGN—Arthur B. Ream, President, Mechanicsburg 43044; Fred R. Denkwalter, Secretary, 848 Scioto Street, Urbana 43078. 2nd Wednesday, monthly.
- CLARK—H. B. Elliott, President, 25 West Harding Road, Springfield 45504; Mrs. Marion L. Wilcoxson, Executive Secretary, 616 Building, Room 131, 616 North Limestone Street, Springfield 45503. 3rd Tuesday monthly.
- DARKE—E. Westbrook Browne, President, 330 West 4th Street, Greenville 45331; Giles Wolverton, Secretary, Darke County Department of Public Health, Court House, Greenville 45331. 3rd Tuesday monthly.
- GREENE—Richard A. Falls, President, 1148 North Monroe Drive, Xenia 45385; Mrs. C. K. Elliott, Executive Secretary, 225 Pleasant Street, Xenia 45385. 2nd Thursday monthly, except July and August.
- MIAMI—Robert L. Sutton, President, 423 West Main Street, Tipp City 45371; Robert J. Price, Secretary, 760 North West-edge Drive, Tipp City 45371. 1st Tuesday monthly.
- MONTGOMERY—W. J. Lewis, President, 2567 Far Hills Avenue, Dayton 45419; Mr. Robert F. Freeman, Executive Secretary, 280 Fidelity Medical Building, Dayton 45402. 1st Friday monthly.
- PREBLE—John D. Darrow, President, 228 North Barron Street, Eaton 45320; J. R. Williams, Secretary, 228 North Barron Street, Eaton 45320. December yearly.
- SHELBY—George J. Schroer, President, 322 Second Avenue, Sidney 45365; Alfonsas Kisielius, Secretary, Ohio Building, Sidney 45365.

Third District

Councilor: Frederick T. Merchant, Marion 43305
1051 Harding Memorial Pky.

- ALLEN—T. L. Edwards, President, 670 West Market Street, Lima 45801; T. D. Allison, Secretary, 401 Metropolitan Bank Building, Lima 45801. 3rd Tuesday monthly (omitting June, July, and August).
- AUGLAIZE—R. S. Sobocinski, President, 7 South Blackhoof Street, Wapakoneta 45895; J. F. Bowling, Secretary, 319 West Spring, St. Marys 45885. 1st Thursday odd months, with exception of July.
- CRAWFORD—Carl Ide, President, 140 Hill Street, Bucyrus 44820; Roy Wildey, Secretary, 130 Hill Street, Bucyrus 44820. Meetings held on call.
- HANCOCK—Joseph G. Barkey, President, 120 West Foulke Street, Findlay 45840; Carson P. Cochran, Secretary, 1725 South Main Street, Findlay 45840. 3rd Tuesday monthly.
- HARDIN—John J. Roget, President, Belle Center 43310; Walter Stoll, Jr., Secretary, 900 East Franklin Street, Kenton 43326. 2nd Tuesday monthly.
- LOGAN—G. E. Munn, President, 120 East Sandusky Street, Bellefontaine 43311; J. Terebuh, Secretary, Colonial Arms Apt. 10, Bellefontaine 43311. 1st Friday monthly.
- MARION—Richard W. Mills, President, 170 Fairfax Road, Marion 43302; Alice F. Fisher, Secretary, 1040 Delaware Avenue, Marion 43302. 1st Tuesday monthly.

MERCER—Cecil E. Pennington, President, 406 South Oak, Coldwater 45828; George H. McIlroy, Secretary, 123 East Fayette Street, Celina 45822. 3rd Thursday monthly.

SENECA—Lowell K. Good, President, 133 West North Street, Fostoria 44830; W. F. Yarris, Secretary, 301 Perry Street, Fostoria 44830. 3rd Tuesday every other month.

VAN WERT—Wilmer L. Iler, President, Medical Arts Building, Fox Road, Van Wert 45891; Fred E. Culler, Secretary, 938 South Washington Street, Van Wert 45891. 4th Friday monthly.

WYANDOT—Robert E. Goynne, President, 482 North 7th Street, Upper Sandusky 43351; Joseph J. Browne, Secretary, 777 North Sandusky Street, Upper Sandusky 43351. 2nd Tuesday monthly.

Fourth District

Councilor: Robert N. Smith, Toledo 43606
3939 Monroe St.

- DEFIANCE—George L. Boomer, President, 1075 East Second Street, Defiance 53512; Miss Lois Coffin, Executive Secretary, P.O. Box 386, Defiance 43512. 1st Saturday monthly.
- FULTON—F. E. Elliott, President, 203 Beech Street, Wauseon 43567; R. L. Davis, Secretary, 137 South Fulton, Wauseon 43567. Quarterly, March, June, September, and December, 2nd Tuesday.
- HENRY—T. F. Moriarty, President, Napoleon 43545; Wilson J. Stough, Secretary, Napoleon 43545. 1st Tuesday monthly.
- LUCAS—George T. Booth, President, 1006 Secor Hotel, Toledo 43603; Mr. Robert W. Elwell, Executive Secretary, 3101 Collingwood Boulevard, Toledo 43610. Council meets on 3rd Tuesday of each month except July and August.
- OTTAWA—V. Wm. Wagner, President, 122 East Perry, Port Clinton 43452; William Coon, Secretary, 120 East Perry, Port Clinton 43452. 2nd Thursday monthly.
- PAULDING—D. P. Ward, President, Box 416, Oakwood 45873; Richard D. Staggs, Secretary, Route 5, Defiance 43512. Meetings held at call of President.
- PUTNAM—A. P. Daniel, President, 144 North Walnut, Ottawa 45875; Oliver N. Lugibihl, Secretary, Pandora 45877. 1st Tuesday monthly.
- SANDUSKY—E. C. Hiestand, President, Old Fort 44861; Mrs. Patsy J. Askins, Executive Secretary, Central Office, Memorial Hospital of Sandusky County, Fremont 43420. 3rd Wednesday monthly.
- WILLIAMS—Robert Bemis, President, 210 Morris Drive, Montpelier 43543; Victor Boerger, Secretary, Edgerton 43517. 3rd Tuesday monthly.
- WOOD—Roger A. Peatee, President, 140 South Prospect Street, Bowling Green 43402; Douglas S. Hess, Secretary, 920 North Main Street, Bowling Green 43402. 3rd Tuesday monthly.

Fifth District

Councilor: P. John Robeck, Cleveland 44106
10525 Carnegie Ave.

- ASHTABULA—S. E. Gates, President, 344 State Street, Conneaut 44030; A. R. DeCato, Secretary, 3903 Lake Avenue, Ashtabula 44004. 2nd Tuesday monthly.
- CUYAHOGA—David Fishman, President, Room 404, 10515 Carnegie Avenue, Cleveland 44106; Mr. Robert A. Lang, Executive Secretary, 10525 Carnegie Avenue, Cleveland 44106.
- GEAUGA—C. K. Adrian, President, Medical Arts Building, 13221 Ravenna Road, Chardon 44024; Mrs. Martha Withrow, Executive Secretary, P.O. Box 249, Chardon 44024. 2nd Friday monthly.
- LAKE—Wm. C. Downing, President, 150 Mentor Avenue, Painesville 44077; Mrs. Owen A. McLaren, Executive Secretary, 7408 Cadle Avenue, Mentor 44060. 4th Wednesday evening of January, March, May, September, and November, unless otherwise ordered by the Council.

Sixth District

Councilor: Edwin R. Westbrook, Warren 44481
438 North Park Ave.

- COLUMBIANA—E. P. Schaefer, President, 412 North Lincoln Avenue, Salem 44460; Mrs. Gilson Koenreich, Executive Secretary, 193 Park Avenue, Salem 44460. 3rd Tuesday monthly.
- MAHONING—Harold J. Reese, President, 3720 Market Street, Youngstown 44507; Mr. Howard C. Rempes, Executive Secretary, 245 Bel-Park Building, 1005 Belmont Avenue, Youngstown 44504. 3rd Tuesday monthly.
- PORTAGE—Alan Yoho, President, 444 South Meridian, Ravenna 44266; Miss Marie Motyka, Executive Secretary, 430 Grant Street, Akron 43311. 3rd Tuesday monthly.
- STARK—M. W. Scott, President, 315 McKinley Avenue, N. W., Canton 44702; Mr. J. H. Austin, Executive Secretary, 405 4th Street, N. W., Canton 44702. 2nd Thursday monthly.
- SUMMIT—L. V. Phillips, President, 2106 Braewick Circle, Akron 44313; Mr. S. H. Mountcastle, Executive Secretary, 430 Grant Street, Akron 44311. 1st Tuesday monthly.

TRUMBULL—Allen L. Schaffer, President, 1227 East Market, Warren 44483; Mrs. Kay Ticknor, Executive Secretary, 280 North Park Avenue, Warren 44481. 3rd Wednesday monthly September through May.

Seventh District

Councilor: Sanford Press, Steubenville 43952
525 North Fourth Street

BELMONT—D. M. Creamer, President, First National Bank Building, Bellaire 43906; Bertha M. Joseph, Secretary, Myers Building, Martins Ferry 43935. 3rd Thursday monthly, except January, May, July, and August.

CARROLL—P. S. Whiteleather, President, Minerva 44657; T. J. Atchison, Secretary, 292 East Main Street, Carrollton 44615. 2nd Tuesday monthly, except July and August.

COSHOCOTON—Donald E. Potts, President, 600 East Main Street, West Lafayette 43845; H. W. Lear, Secretary, 345 South 4th Street, Coshocton 43812. 2nd Tuesday monthly.

HARRISON—Charles Evans, President, 159 South Main Street, Cadiz 43907; G. E. Vorhies, Secretary, Scio 43988. 3rd Wednesday, March, June, September and December.

JEFFERSON—Lee A. Rosenblum, President, 114 Brady Circle, E., Steubenville 43952; Raymond B. Cagina, Secretary, 909 3rd Street, Brilliant, Ohio 43913. 4th Tuesday monthly except no meeting in December, January, and February.

MONROE—Byron Gillespie, Secretary, Woodsfield 43793.

TUSCARAWAS—James F. Zeller, President, 250 West High Avenue, New Philadelphia 44663; C. Raymond Crawley, Secretary, 232 West Third Street, Dover 44622. 2nd Wednesday or Thursday monthly.

Eighth District

Councilor: James A. Quinn, Newark 43055
1320 W. Main Street

ATHENS—Herbert Whanger, President, Box 238, Athens 45701; L. A. Hamilton, Secretary, 400 East State Street, Athens 45701. 2nd Tuesday monthly, except July and August.

FAIRFIELD—Andrew Essman, President, 703 West Sixth Avenue, Lancaster 43130; C. R. Reed, Secretary, 124½ West Main Street, Lancaster 43130. 2nd Tuesday monthly.

GUERNSEY—John P. Haun, President, 1432 Clark Street, Cambridge 43725; Dayle O. Snyder, 100 Clark Court, Cambridge 43725. 1st Tuesday evening monthly.

LICKING—Warren Koontz, President, 99 Hudson Avenue, Newark 43055; Robert T. Parker, Secretary, 117 East Elm Street, Granville 43023. 4th Tuesday monthly.

MORGAN—Asa Whitacre, President, Chesterhill 43728; Henry Bachman, Secretary, Malta 43758.

MUSKINGUM—W. W. Renner, President, 812 Market Street, Zanesville 43701; Myron H. Powelson, Secretary, 2825 Maple Avenue, Zanesville 43701. 1st Tuesday monthly.

NOBLE—Frederick M. Cox, President, Caldwell 43724; Edward G. Ditch, Secretary, Caldwell 43724. 1st Tuesday monthly.

PERRY—Charles E. Bope, President, Somerset 43783; Michael P. Clouse, Secretary, Somerset 43783.

WASHINGTON—Archbold M. Jones, President, 326 Third Street, Marietta 45750; Tom D. Halliday, Secretary, 409 Second Street, Marietta 45750. 2nd Wednesday monthly.

Ninth District

Councilor: Oscar W. Clarke, Gallipolis 45631
4th & Sycamore St.

GALLIA—Gene Abels, President, Holzer Hospital, Gallipolis 45631; Lewis A. Schmidt, Secretary, Gallipolis Clinic, Gallipolis 45631.

HOCKING—Jan S. Matthews, President, 9 East 2nd Street, Logan 43138; J. W. Doering, Secretary, 42 North Spring Street, Logan 43138. 2nd Tuesday monthly.

JACKSON—Carl J. Greever, President, 35 Vaughn Street, Jackson 45640; John W. Zimmerly, Secretary, 35 Vaughn Street, Jackson 45640. No set date for meetings.

LAWRENCE—Rudolph Avalos, President, 1915 S. 6th Street, Ironton 45638; George Newton Spears, Secretary, 2213 South Ninth Street, Ironton 45638. Quarterly at called times.

MEIGS—Charles J. Mullen, President, 210½ East Main Street, Pomeroy 45769; E. Butrimas, Secretary, 204 East Main Street, Pomeroy 45769. Meetings as needed.

PIKE—A. M. Shrader, President, 196 Emmitt Avenue, Waverly 45690; Janie Hwang, Secretary, 400 Cherry Street, Waverly 45690. 1st Tuesday monthly.

SCIOTO—Chester H. Allen, President, 1405 Offnere Street, Portsmouth 45662; Erich Spiro, Secretary, 1735 Waller Street, Portsmouth 45662. February, April, July, October, and December (may be changes).

VINTON—Richard E. Bullock, President, 203 South Market Street, McArthur 45651.

Tenth District

Councilor: Richard L. Fulton, Columbus 43212
1211 Dublin Rd.

DELAWARE—C. S. Hambrick, President, Box 265, Delaware 43015; Tennyson Williams, Secretary, Box 265, Delaware 43015. 3rd Tuesday monthly.

FAYETTE—J. H. Persinger, President, 225 East Market Street, Washington C. H. 43160; M. H. Roszmann, Secretary, 1005 Temple Street, Washington C. H. 43160. 2nd Friday, noon, monthly.

FRANKLIN—Tom F. Lewis, President, 350 East Broad Street, Columbus 43215; Mr. W. "Bill" Webb, Executive Secretary, 17 South High Street, Suite 528, Columbus 43215. 3rd Tuesday monthly.

KNOX—Richard L. Smythe, President, 812 Coshocton Avenue, Mount Vernon 43050; Robert E. Sooy, Secretary, 812 Coshocton Avenue, Mount Vernon 43350. 1st Wednesday monthly, except July and August.

MADISON—John Starr, President, 196 Elm Street, London 43140; Martin Markus, Secretary, High Street, London 43140.

MORROW—Lowell Murphy, President, 209 South Marion Street, Cardington 43315; David James Hickson, Secretary, 712 Baker Street, Mt. Gilead 43338. 1st Tuesday monthly, 6:30 P. M. dinner.

PICKAWAY—Edward L. Montgomery, President, 213 East Main Street, Circleville 43113; Carlos Alvarez, Secretary, 147 Pinkney Street, Circleville 43113. 1st Friday monthly, except July and August.

ROSS—Richard L. Counts, President, 56 East Second Street, Chillicothe 45601; Walter Kramer, Secretary, 39 West Main Street, Chillicothe 45601. 1st Thursday monthly.

UNION—Malcolm MacIvor, President, 110 North Court Street, Marysville 43040; May B. Zaugg, Secretary, 130 North Maple Street, Marysville 43040. 1st Tuesday February, April, October, December.

Eleventh District

Councilor: William R. Schultz, Wooster 44691
1749 Cleveland Road

ASHLAND—Jack E. Irvine, President, 231 West Main Street, Ashland 44805; Lorand C. Reich, Secretary, 127 North Water Street, Loudonville 44842. 1st Thursday monthly.

ERIE—W. P. Skirball, President, 1218 Cleveland Road, Sandusky 44870; Mrs. David Wolfert, Executive Secretary, 1428 Holly-road Road, Sandusky 44870. 2nd Tuesday monthly.

HOLMES—Charles H. Hart, President, 109 South Clay Street, Millersburg 44654; William A. Powell, Secretary, 8 West Adams Street, Millersburg 44654. 3rd Thursday monthly at the Village Restaurant, Millersburg.

HURON—Richard L. Jackson, President, 15 East Emerald Street, Willard 44890; John Rosso, Secretary, 218 Myrtle Avenue, Willard 44890; 2nd Wednesday of February, April, June, August, October, and December.

LORAIN—Robert S. VanDevort, President, 230 Hamilton Avenue, Elyria 44035; Mrs. Gladys Davidson, Executive Secretary, 428 West Avenue, Elyria 44035. 2nd Tuesday monthly, except June, July, and August.

MEDINA—B. A. Kassel, President, 750 East Washington Street, Medina 44256; Mr. A. Dana Whipple, Executive Secretary, 320 East Liberty Street, Medina 44256. 3rd Thursday monthly.

RICHLAND—Wendell M. Bell, President, 480 Glessner Avenue, Mansfield 44903; Mrs. M. K. Leggett, Executive Secretary, Mansfield General Hospital, Mansfield 44903. 3rd Thursday monthly.

WAYNE—Lyle Moyer, President, Dalton 44618; R. J. Watkins, Secretary, 1736 Beall Avenue, Wooster 44691. 2nd Wednesday, alternate months.

Dr. Earle B. Kay, chief of thoracic and cardiovascular surgery, St. Vincent Charity Hospital, Cleveland, was principal speaker at the annual meeting of the Erie County Branch of the Heart Association in Sandusky. His topic was "New Horizons in Heart Surgery."

Dr. and Mrs. Lawrence C. Meredith, Elyria, were elected cochairmen of the Oberlin Senior High School PTA to serve for the coming school year. Dr. Meredith completed a year as President of the Ohio State Medical Association in May.

Dr. Lester Adelson, chief deputy coroner of Cuyahoga County, spoke at a dinner meeting in Cleveland at which Clinical Pathologists of Cleveland were hosts to the Society of Medical Technologists. His topic was "The Forensic Pathologist on Homicide."

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Dr. Robert H. Browning, professor of medicine (pulmonary diseases) at Ohio State University College of Medicine, was speaker at the annual meeting of the Warren County Tuberculosis and Health Association at Morrow. His topic was "Smoking and Health Problems."

JOURNAL ADVERTISERS

Advertisers in *The Journal* are friends of the profession. By accepting their advertising we show confidence in them and in their services and products. They underwrite a large portion of the printing cost of *The Journal*, and help make it a quality publication. In return we place their messages on the desks of Ohio's physicians. Please familiarize yourself with their services and products, and let them know that you see their advertising in *The Journal*.

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Editorial:

Proposed New Design for Mental Health in Ohio

An article by Dr. Norman Clemens of University Hospitals, Cleveland, entitled "Psychiatric Emergencies and the State Hospital System in Cleveland," appears on page 907. It is a lucid, factual summary of what happened to a group of acutely mentally ill patients seen in an average month in a hospital emergency room (November, 1966). Twenty-two of these patients, because of serious danger to themselves and the community, required immediate admission to a state hospital.

They were refused.

The strain on family, the doctors, and hospital personnel confronted with these recurring, hazardous situations is well known to mental health workers in Cuyahoga County. It spells out the consequences of "no beds—insufficient staff" in dramatic terms.

Dr. Clemens' article raises an important question: How well does the Department of Mental Hygiene and Correction in Ohio do its statutory job of taking care of our mentally ill?

Since October, 1962, when the Ohio State Medical Association sent a delegation to the American Medical Association's First Conference on Mental Health, the OSMA Committee on Mental Health and the Ohio Psychiatric Association have studied and appraised our State's effort. Evaluated by medical standards, it is poor. In 13 of 15 criteria established by the American Psychiatric Association and the National Association For Mental Health, Ohio ranks in the lower half of all the states, placed in a category with the poorest farm states. Ohio is 14th in per capita income but ranks 47th in money spent for mental health.

Harold M. Visotsky, M.D., Director of the Illinois Department of Mental Health, has accurately observed, "You have essentially been running custodial programs in your large state hospitals. If you want to change from a custodial to a treatment program, then the average cost per day must be at least doubled and, if you want to run an effective program, it must be at least tripled."

Ohio lags far behind other industrial states in devotion to mental health because its Department of Mental Hygiene and Correction is an anachronistic hybrid because it is tied to political exigencies, not primarily to medical needs. The state hospital is subject to the interest, the sophistication, the bias of the incumbent governor. He is not obliged to choose a director of the combined divisions with any special training in medicine, psychiatry, in hospital adminis-

tration, or in the understanding and treatment of criminals.

The chief administrator of the department, therefore, is essentially a political officer whose primary loyalty must be to his party and to his governor. This has caused an unbridgeable schism between the commissioners of the Division of Mental Hygiene and the upper echelons of departmental power where the serious decisions are made concerning planning for care and treatment, designing and distributing facilities, evaluating budgetary needs and making value judgments about personnel. There have been 13 changes of commissioners in about 20 years. Many have resigned in protest because they could not communicate nor find acceptance for a medically oriented program designed to *treat* patients not merely *house* them.

This is a prominent reason why well-qualified, skilled personnel rarely come to work in the Ohio state hospital system. *Recruitment, despite increase in salary levels, will never bring professionals into Ohio until they are offered continuity of program and trusted leadership identified with medicine and divorced from politics.*

The establishment of a separate Department of Mental Health has been a primary recommendation dating back to 1953 and even earlier when mental health was under the sprawling Ohio Welfare Department. Members of the OSMA Committee on Mental Health and the Ohio Psychiatric Association have for many years quietly worked toward bringing about the division of the present Department into two separate, independent departments, one of Mental Health, the other of Corrections, each to stand on its own, to be identified for its unique purposes, to devise its own programs, and to seek its own way before the various legislatures.

To establish rational goals, policies and standards of operation, a Mental Health Council with strong representation from medicine has been envisaged to make constructive liaison between the Governor and the Department of Mental Health.

A bill, H. B. 489, strongly endorsed and actively supported by the OSMA and the OPA, has been introduced into the present session of the Ohio General Assembly to bring about creation of the two separate departments and a medically oriented regulatory council for mental health.

H. B. 489 offers Ohio a chance to create a new model for the dispensation of sound medical care for its mentally ill and mentally retarded. If the bill becomes law, Ohio may well attract and hold topflight careerists in mental health, with inevitable reward to the patient, the population, the community, and the state.

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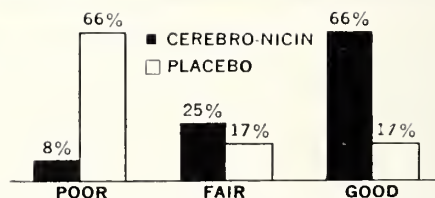
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Ohioans Serve as Civilian Physicians in Vietnam

Two Ohio physicians were serving in South Vietnam under the Volunteer Physicians for Vietnam program sponsored by the American Medical Association, according to the latest report received by *The Journal*.

Dr. Robert G. Smith, Circleville, was scheduled to complete a tour there in early July. He is a graduate of Ohio State University College of Medicine, class of 1931, and practices general surgery in the Circleville area.

Dr. Clinton W. Trott, general practitioner of Mt. Vernon, is also scheduled to complete a 60-day tour early in July. He is a graduate of Loma Linda University, California, class of 1940.

The AMA gives the following background for the program: Twenty-five years of war and insurrection in the area now known as South Vietnam has placed tremendous health burdens on the people. To the ever-present diseases and malnutrition of Southeast Asia have been added war injuries, disruption of whatever public health measures existed, and a serious lack of doctors and nurses as more and more of the country's approximately 1,000 physicians were called into military service. Today only about 350 physicians are left to administer health care to 15 million Vietnamese civilians.

South Vietnamese authorities have asked the United States government to encourage American physicians to volunteer their services to Vietnamese civilians.

Out of this request grew a program financed by the U. S. government through the State Department's Agency for International Development (AID). Created to recruit U. S. physicians for volunteer 60-day tours of service at Vietnamese civilian hospitals, the program was at first administered by People-to-People Health Foundation, Inc., with the American Medical Association assisting in recruit-

ment. At this point the program was called Project Vietnam.

After successfully implementing Project Vietnam on a pilot basis, People-to-People Foundation asked that the program be turned over to some other responsible agency, preferably the AMA. At the invitation of the Agency for International Development, the AMA assumed administrative responsibility on June 30, 1966, when the contract between the USAID and People-to-People Health Foundation, Inc. terminated. Under the aegis of the AMA, the program is known as AMA Volunteer Physicians for Vietnam.

Ohio Physician Is President of Christian Medical Society

Arthur H. Svedberg, M. D., was installed as president of the Christian Medical Society on May 6. Dr. Svedberg practices internal medicine and cardiology in Lyndhurst, Ohio.

The Christian Medical Society gives the following information as to its structure and purposes: It is an organization of 3,500 doctor members. It has 186 chapters in the United States and Canada, and 800 missionary members in all parts of the world. The purpose of this interdenominational group is "to present a positive witness to Christ in and through the medical professions."

During his term as president of the Christian Medical Society, which extends to May, 1969, Dr. Svedberg will be traveling to represent the Society at professional and religious meetings.

Activities of the Christian Medical Society include educational conferences, medical student assistance, short-term missions, clinics in metropolitan areas, and study of ethical issues in religion and medicine.

There are CMS chapters in Cleveland, Cincinnati, Columbus, and Dayton.

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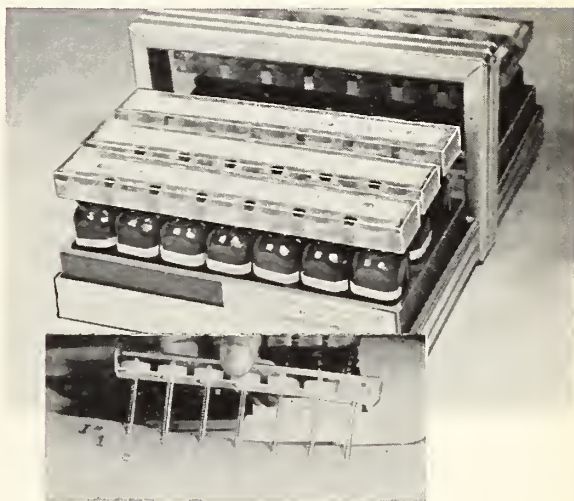
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WMA Individual Memberships Now Open to All AMA Members

Individual membership in the World Medical Association is now open to all members of the American Medical Association, according to a WMA announcement.

Dues are \$10 per year. This includes a subscription to *World Medical Journal* and the privilege of participation in the World Medical Assembly each year.

The 21st World Medical Assembly will be held in Madrid, Spain, September 10-17, 1967. The 1968 Assembly will be held in Australia.

The World Medical Association is a society of the free, professional medical associations of the free nations. Sixty national medical associations are members, including the AMA.

The 20th World Medical Assembly last winter in Manila created for the first time an individual associate membership within the WMA. Members of the national medical associations may now join WMA as individuals.

Gerald D. Dorman, M.D., of New York City, member of the AMA's Board of Trustees, is chairman of the Council, governing body of the WMA. The WMA Headquarters Secretariat is located at 10 Columbus Circle, New York City. Secretary General is Alberto Z. Romualdez, M.D.

Application for individual membership may be made to WMA at the New York City office. Applications should be accompanied by a check for \$10, with a statement that the applicant is a member in good standing of AMA. The letter should specify whether the applicant wishes to receive the *World Medical Journal* in the English, Spanish, or French language edition. Checks should be made payable to The World Medical Association, Inc., a tax-exempt organization. Five-year memberships are available for \$50. Information regarding the 21st World Medical Assembly will be mailed promptly to all applicants for individual membership.

"The World Medical Association," said Dr. Dorman, "is uniquely qualified to act as a force for peace and understanding in the world today. WMA is a very real and vital part of the world health picture, continually seeking to solve world medical problems through the community spirit and action of its professional membership."

Dr. Dorman made it clear that The World Medical Association has no connection with any government, that it is omitted to the philosophy that medical and scientific knowledge should be universally available and free of all political control.

Dr. Barnet R. Sakler, Cincinnati, was installed as president of the American Association of Ophthalmology at its recent meeting in Chicago. Another Ohioan, Dr. Charles E. Jackle, of Defiance, is a member of the executive committee.

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Warning: If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with great caution in the first trimester of pregnancy.

Precautions: Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should be closely supervised and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools or other evidence of intestinal hemorrhage. Make regular blood counts. Discontinue the drug and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The most common are nausea, edema and drug rash. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. Infrequently, agranulocytosis, or a generalized allergic reaction may occur and require withdrawal of medication. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

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Sanitary Code and Maternity Hospitals...

Newly Adopted Regulation Authorizes Admission of Noninfectious Gynecologic Patients to Obstetric Beds Under Certain Conditions

A REGULATION has been adopted by the Public Health Council of Ohio effective July 1, 1967, authorizing the admission of noninfectious gynecologic patients to obstetric beds in maternity hospitals under conditions specified in the regulation. The regulation, adopted on May 20 of this year, was forwarded to *The Journal* by Dr. Emmett W. Arnold, director of the Ohio Department of Health, and William H. Veigel, secretary of the Public Health Council. Following is the text of the regulation which is now a part of the Ohio Sanitary Code.

STATE OF OHIO DEPARTMENT OF HEALTH PUBLIC HEALTH COUNCIL MATERNITY HOSPITALS CHAPTER HE-7

Regulation HE-7-08.01 of the Ohio Sanitary Code, in final form, to authorize the admission of noninfectious gynecologic patients to obstetric beds in maternity hospitals.

Authority: Sections 3701.13, 3701.34 and 3711.01 to 3711.13, inclusive, of the Revised Code

HE-7-08.01. Integration of noninfectious gynecologic patients with obstetric patients.

(A) Notwithstanding the provisions of regulation HE-7-08 of the Ohio Sanitary Code, the administrator or other authorized representative of a person maintaining a maternity hospital may make application to the director of health for approval to admit selected noninfectious gynecologic patients to a maternity hospital. The application shall be made on forms prescribed and provided by the director of health and shall be supported by such additional evidence as the director may require. The director of health shall grant approval for the admission of selected noninfectious gynecologic patients to such hospital if he is satisfied that:

(1) The average occupancy for maternity beds in the hospital has been less than sixty-five per cent (65%) during the six (6) months period preceding application and that it is not feasible nor advisable to reduce the size of the maternity division by structural change;

(2) The average occupancy of beds for the medical-surgical services, exclusive of maternity

and pediatric beds, has exceeded seventy-five per cent (75%) during the six (6) months period preceding application;

(3) The types of selected gynecologic cases submitted on the application, for admission to the maternity unit, have been approved by the medical staff of the hospital;

(4) The hospital has a combined obstetrical and gynecological department of the medical staff;

(5) A physician certified or eligible to be certified in obstetrics and gynecology by the American board of obstetrics and gynecology, or a physician certified or eligible to be certified in obstetrics and gynecology by the board of trustees of the American osteopathic association, or a physician competent in obstetrics and gynecology as determined by the hospital medical staff, is the chief of the obstetrical service and shall assume the responsibility for medical staff adherence to the requirements and conditions for admitting selected noninfectious gynecologic patients to obstetric beds.

(B) A maternity hospital approved under division (A) of this regulation shall comply with the following admission practices and procedures:

(1) The medical record of a gynecologic patient shall show the written approval of the chief of the obstetrical service or his designee prior to or within twenty-four hours after admission of the patient;

(2) Gynecologic patients shall be admitted directly and shall not be transferred from a non-maternity service of any hospital to the maternity unit;

(3) Obstetric and gynecologic patients shall not occupy the same room;

(4) If an active potentially transmissible infectious condition is detected at any time, the patient shall be transferred from the maternity unit immediately or as soon as possible;

(5) Gynecologic surgery shall not be performed on the nonobstetrical patient in a delivery room or suite;

(6) Postoperative gynecologic patients shall not be admitted to the delivery recovery room;

(7) Gynecologic patients returning from surgery shall either bypass the general surgery recovery

ery room or may be admitted to a separate clean section of the general surgery recovery room;

(8) The length of stay of any gynecologic patient in the maternity unit shall not exceed fourteen (14) days, except by specific written approval of the chief of the obstetrical service;

(9) No gynecologic patient may be admitted or retained in a maternity unit to the exclusion of a maternity patient. To assure compliance with this provision, a sufficient reserve of unoccupied obstetric beds shall be maintained at all times.

(C) The following gynecologic patients shall not be admitted to the maternity unit:

(1) Any patient with an oral admission temperature of over one hundred and four tenths degrees (100.4°) Fahrenheit;

(2) Any patient with a known or questionable infectious or septic condition;

(3) Any patient who requires radium or radiation therapy including isotope therapy;

(4) Any patient who has a gynecologic condition with another significant medical or surgical condition, which requires medical or surgical care in addition to gynecologic care;

(5) Any patient with invasive carcinoma;

(6) Any patient who has a personal history of staphylococcal infection occurring within one month prior to admission, or has had a severe diarrheal disease during the week prior to admission, or has had close contact with a person having such a history.

(D) A hospital approved under division (A) of this regulation shall comply with the following nursing personnel requirements:

(1) The nursing care of maternity, newborn, noninfectious gynecologic patients shall be supervised by the obstetrical nursing supervisor;

(2) Nursing personnel assigned to the combined noninfectious gynecologic and obstetric service shall not have been assigned to any other service during the same workday;

(3) Nursing personnel working on the combined noninfectious gynecologic and obstetric service shall not later work in the labor room, delivery room, or newborn nursery during the same workday;

(4) Nursing personnel working on the combined noninfectious gynecologic and obstetric service shall not later care for, or supervise the care of newborn infants during the same workday.

(E) A hospital approved under division (A) of this regulation shall keep such records and submit such reports as may be required from time to time by the director of health, and such records shall be available for inspection at all reasonable times by the director of health or his authorized representatives.

(F) Visitation privileges for gynecologic patients admitted to the maternity unit of a hospital shall be the same as for maternity patients as provided by regulation HE-7-17 of the Ohio Sanitary Code.

(G) The director of health shall withdraw any approval granted under division (A) of this regulation if the person maintaining such hospital does not operate the maternity hospital in compliance with this regulation.

(Adopted May 20, 1967; effective July 1, 1967.)

Head of Pathology at Ohio State Retires from Chairmanship

Dr. Emmerich von Haam, chairman of the Department of Pathology at Ohio State University College of Medicine since 1937, has retired from that post effective this summer. He will continue his teaching and research activities in the Department.

Named to succeed Dr. von Haam as chairman of the Department is Dr. Jack C. Geer, of San Antonio, Texas, professor of pathology at the University of Texas South Texas Medical School. Dr. Geer is a graduate of Louisiana State University School of Medicine, class of 1950, and from 1961 to 1966 was director of the medical technology section at Louisiana State's Department of Pathology.

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STANLEY LUCAS, M.D.*

PART II

(Continued From June Issue)

IN 1900, the *Cincinnati Lancet Clinic* reported the formation of the first national x-ray organization, the Roentgen Society of the United States which was to have its first meeting in New York City in December, 1900 at the Grand Central Palace Hotel, Lexington Ave. Corner.

In 1901, the *Cincinnati Journal* reported on the paper by Becquerel at the Astronomical Society in Paris describing the extraordinary properties of the new element—radium, which “when brought into light shines with a brilliancy surpassing that of an electric arch.”

By 1902, Cincinnati physicians were active in the therapeutic uses of radiation. Dr. William J. Taylor, an electrotherapist, reported the use of x-ray for relief of pain in nine cases with rheumatism. He and Dr. Percy Shields also reported on radiation therapy for epithelioma. Dr. Shields preferred the use of a high frequency coil to the static machine, because of the constancy of action and the shortness of exposure. His so-called soft tube had an adjustable vacuum and a 6 inch distance from tube to the skin with the remainder of the head and body protected by tin foil and lead plaster.

Dr. E. H. Shields, brother of Dr. Percy Shields, and Professor of Dermatology at the Cincinnati and Miami Medical College, reported at this time on the use of x-ray in the treatment of laryngeal and tonsillar carcinoma. Dr. Heidingsfeld, Professor of Dermatology at the Laura Memorial Medical College, Cincinnati, reported on the use of the Kinraide coil and the Swett and Lewis tube with 6 inch distance and 5½ inch spark gap in the treatment of chronic eczema, lupus vulgaris, and in alopecia areata (Fig. 2). Nationally, papers were appearing and reported in the *Cincinnati Journal* on the use of x-ray in cancer of the uterus. (E. Stuver, Fort Collins, Colorado).

Dr. S. P. Kramer published a paper in the *Cincinnati Lancet Journal* titled “A New Method For

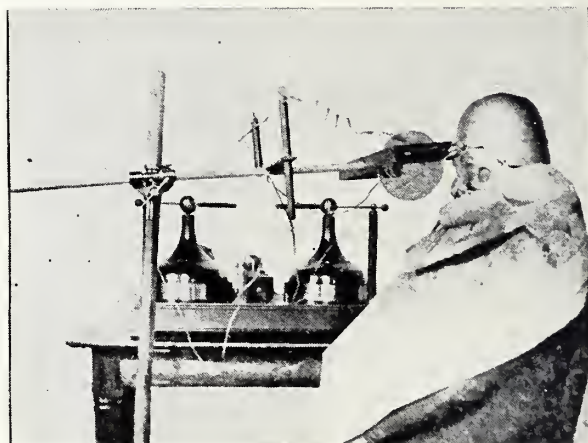


FIG. 2. Demonstration of the therapeutic use of the Kinraide coil and Swett and Lewis tube by Dr. Heidingsfeld in 1902. The Cincinnati Lancet Clinic.

Locating Foreign Bodies By Means Of The X-Rays” in which he used needles inserted at right angles to each other for triangulation and location of the foreign body. Dr. Percy Shields in this year (1902) noted that x-ray therapy for epitheliomas about the eyelid resulted in healing with less deformity than treatment with surgery alone.

In 1902, editorially, the *Cincinnati Lancet Clinic* summarized

Six years ago, the x-ray apparatus was universally regarded with suspicion. Today, nearly every up-to-date physician has a Kinraide coil (Fig. 3), which he instantly attaches to an ordinary incandescent light socket and conducts a thorough x-ray examination or treatment, neatly, quickly, and almost without expense. . . . The Kinraide coil was the sole product of Swett and Lewis of Boston, Mass., who first started business in 1897 in a 10 x 12 foot floor space. In the period of 5 years, the company found it necessary to double and even triple their capacity many times.

In announcements of the third annual meeting of the American Roentgen Ray Society, at the Sherman House in Chicago, on December 10-11, 1902, it was noted

after the travail of its birth and the hardships of its infancy, the Society is surely establishing itself on a sound ethical basis and has every prospect of a useful and prosperous future. . . . It is the hope of this Society to serve a useful purpose in encouraging on the one hand a proper under-

*Dr. Lucas, Cincinnati, is Radiologist, Jewish Hospital; Attending Radiologist, Cincinnati General Hospital; Assistant Clinical Professor of Radiology, The University of Cincinnati College of Medicine.

Submitted October 24, 1966.



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Cautions and Contraindications: No adverse effects on blood pressure, heart rate, and respiration have been reported. However, as is true for all medications of this type, PLEGINE (Phendimetrazine bitartrate) is not recommended for patients with coronary disease, severe hypertension, or thyrotoxicosis, and should be used with caution in highly nervous or agitated individuals.

Side Effects: There have been occasional reports of insomnia and nervousness. Rare instances of mouth dryness, nausea, blurring of vision, dizziness, constipation, and stomach pain have been noted.



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standing of the uses and limitations of the x-ray and on the other hand to limit and control the inevitable abuses which are now springing upon us.

In the March, 1902, edition of the *Cincinnati Eclectic Medical Journal*, the medical-legal aspects of x-rays were again discussed when a prominent Common Pleas judge of Hamilton County admitted evidence of the shadowgraphs of the x-ray, with the following comments:

I believe that this is an innovation that will eventually result in a mistrial. . . .

The x-ray operator may so manipulate the shadowgraph as to greatly disturb the appearance of a fractured bone. . . .

It is my judgment that if the x-ray is admitted in court trials, it should be taken with the greatest degree of allowance, and that the operator should be sworn as to the position of the plate, the exposed limb and the distance of the x-ray tube from the object shadowgraph.

—[Truly a wise judicial decision for the importance of details.]

1903 - 1906

In July, 1903, John Uri Lloyd, a Cincinnati pharmacist, active in the Eclectic Medical Institute, a liberal contributor to scientific journals as an authority on botanical chemistry, active principles and the art of pharmacy and a founder of the recently merged Lloyd Brothers pharmaceutical firm, gave an excellent address before the Ohio State Eclectic Medical Society on radiant energy. At the last minute, he changed the original subject of his planned talk to discuss this problem of radiant energy which he felt was almost

paralyzing with excitement the advanced thinkers in scientific circles. . . . What is it that within a few brief months has thrust itself so conspicuously upon the world of science as to lead to innumerable newspaper and magazine articles, seemingly discrediting the science of recent years, and also leading to speculations in the world of science that seem almost inclined to shatter the lessons we have learned during our wandering study of the past? What is that, under the simple word "radium" and a compound term "radiant energy" has thrust itself upon our attention from out the unknown space which lies in the illimitable depths not yet traversed by thought or speculation, almost as a meteor flashed into existence from out of the depths of astronomical vacancy?

My aim is to ask my hearers to reject all idea of the "miraculous" and to eschew the word "super-natural." I beg you to remember that the one word *Law* covers all that is in science and in fact. Remember, furthermore, that the word *Order* invariably accompanies the word *Law*, and bear in mind that the word *miracle* does not belong to the field of men who deal in the field of force, energy, and of science.

In the meantime, additional reports appeared concerning the use of x-ray and radium rays in the treatment of cancer. The danger of these rays leading to death of living cells and even death of the animal if given in sufficient doses was already noted. The necessity of determining sharply between the limits of danger and benefit was being discussed and written about.

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FIG. 3. Advertisement of Swett and Lewis Company, 1902, promoting one of the early successful sources of potential for x-ray tubes. The Cincinnati Lancet Clinic.

The Lancet Journal noted in 1903 that W. B. Saunders Company published a book on "The Practical Application of The Roentgen Rays In Therapeutics And Diagnosis" and written by Drs. William Pusey and Eugene Caldwell.

Apparently some difficulty occurred in 1903 between the President and the Board of Directors of the University of Cincinnati prompting the *Cincinnati Lancet Journal* to sarcastically note that

the President is apparently making desperate efforts to obtain a modicum of radium, whether for the purpose of being able to outshine the Board or to throw a transcendent glow over their mutual disputations is not yet apparent.

In 1904, Dr. W. Jordan Taylor, Electro-Therapeutic editor of the *Cincinnati Lancet Clinic*, returning from the St. Louis meeting of the American Electro-Therapeutic Association, editorialized on the dangers to x-ray operators, especially of dangers to the skin and extremities, to the impairment of vision, to the diminution of sexual power, and to the "danger of collapsing of Crook tubes, with cutting of the flesh by the flying fragments." During x-ray exposure, the wearing of gloves and coats, lined by tin foil, and apparently first devised by Dr. Price of Cleveland, was suggested.

(Continued in August Issue)



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Statistics on Expectation of Life at Age 45 and Above

In the past quarter century, the expectation of life at age 45 increased by about 1½ years for men and 4 years for women, to 27.1 and 32.5 years, respectively. These gains resulted largely from decreases in mortality during the decade following the close of World War II, with relatively little change during the past ten years.

Future advances will depend for the most part upon the progress made against the degenerative diseases, inasmuch as the mortality from other causes is already at a low level.

The largest increase in the expectation of life at age 45 would result from greater control of the cardiovascular-renal diseases, now the leading cause of death at ages 45 and over. Even a 10 per cent reduction in mortality from these conditions would add about two thirds of a year to the life expectancy of people in their 40's and 50's.

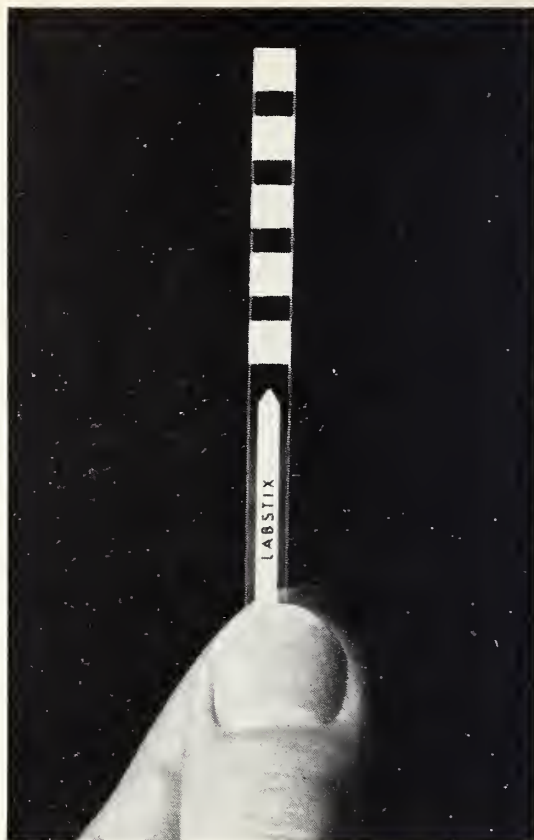
In the event of a major breakthrough, with 30 per cent of these deaths eliminated, the gains at these ages would amount to more than two years. At age 65 a 10 per cent reduction in mortality from this cause would produce a gain of about three fifths of a year, while a 30-per cent reduction would extend expectation of life about two years.

The cardiovascular-renal diseases encompass a large number of conditions, some of whose etiology is unknown. Noteworthy progress has already been made in the prevention and treatment of some of these conditions, such as nephritis, diseases of rheumatic and infectious origin, and vascular lesions affecting the central nervous system. There is reason to expect some further control of these conditions as well as of coronary artery disease, the recorded death rate for which has been on the rise.

Malignant neoplasms rank second as a cause of death. A 10 per cent reduction in the mortality from this cause would contribute only about one fifth of a year to the expectation of life at age 45. However, a decline of as much as 30 per cent in the mortality from cancer would add almost two thirds of a year to the expectation of life at this age and about two fifths of a year at age 65.

Accidents exact a heavy toll of life among young people. At the middle and older ages, however, the years of life that could be gained through reductions in such fatalities are relatively small. Even the elimination of 30 per cent of such deaths at ages 45 and over would add only about one tenth of a year to the expectation of life at age 45.—*Metropolitan Life*

Dr. James B. Johnson, Jr., Newark, Ohio, was chairman of a symposium sponsored by the National Society for Crippled Children and Adults in Pittsburgh on the subject of the paraplegic patient. He is a member of the national organization's board of directors.



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New Members . . .

Following are names of new members of the Ohio State Medical Association certified to the headquarters office during May. List shows name of physician, county, and city in which he is practicing, or in which he is taking postgraduate work.

Allen

William R. Hanna, Lima

Crawford

Antonio M. Rondon, Galion
Donald E. Widman, Galion

Cuyahoga

Jorge P. Alonso, Cleveland
Donald P. Becker, Cleveland

Franklin

Robert F. Chosy, Worthington
Lionel E. Dorfman, Columbus
William V. Nick, Columbus
Charles E. Reier, Columbus
Patrick C. Winans, Fairborn

Jefferson

Milorad M. Milic, Steubenville

Lorain

Francisco S. Floro, Lorain

Lucas

Glidden L. Brooks, Toledo
James G. Diller, Toledo
Nonito M. Sablay, Toledo
Marvin Weisbard, Cincinnati

Mahoning

Mary L. McKenzie,
Youngstown

Montgomery

Michael Kelly, Dayton
Arie D. Verhagen, Dayton

Richland

Hart N. Guonjian, Mansfield

Seneca

Roberto R. Pararigan, Tiffin

Summit

Robert C. Burns, Akron
Alfredo V. Casino, Barberton

Medical Aspects of Sports Conference Is Scheduled

The Ninth National Conference on the Medical Aspects of Sports, sponsored by the American Medical Association under the auspices of its Committee on the Medical Aspects of Sports, will be held in Houston, Texas, at the Hotel America on November 26, 1967. The Conference is held annually in conjunction with and on the first day of the Clinical Convention of the American Medical Association.

As was true of the previous eight Conferences, the Ninth will cover a wide range of subjects of interest to those serving school and college athletic programs. Included will be forums and discussion sections relating to prevention of knee injuries, sports cardiology, and quackery in sports.

Two sessions will be devoted to a series of common clinical conditions of rather variable significance in the athletic setting (e.g., gastroenteritis, concussions, genitourinary tract injuries, and rib injuries). At the Conference Luncheon, Eduardo Hay, M.D., Director General of the Centro Deportivo Olimpico Mexicano, will discuss the preparations for the 1968 Olympic Games.

The Conference is open to key nonmedical athletic personnel as well as interested physicians. Those who would like to receive further information concerning the Conference should address the Committee on the Medical Aspects of Sports, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

Dr. Thomas E. Shaffer, Columbus, is a member of the AMA Committee on the Medical Aspects of Sports.

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Scientific Section

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JULY, 1967

No. 7

Psychiatric Examinations at Lima State Hospital

J. O. CRIST, M.D.

PSYCHIATRIC examinations are done at Lima State Hospital on two kinds of observation cases: The 30 day observation case as sent by the courts pursuant to the provisions of Section 2945.37 R. C. O., "Inquiry into sanity of defendant" or Section 2945.40, "Expert witnesses in insanity cases"; and the 60 day observation case as sent by the courts pursuant to the provisions of Section 2947.25 R. C. O., "Psychiatric examination before sentence; hearing or report of examination." These are the so-called Ascherman Cases (the Ascherman Act comprises Sections 2947.25 through Section 2947.28 R. C. O.).

Only persons who have violated or are alleged to have violated a Section of the General Code of Ohio are accepted for observation and examination. We do not accept persons charged with violations of a municipal ordinance.

Insanity as a Defense

I will first talk about the person committed to Lima State Hospital under the provision of Section 2945.40 in which insanity is set up as a defense, or in which present insanity of the accused is under investigation by a court or jury. The defense attorney, the prosecuting attorney or the Grand Jury before or after trial can suggest to the court that the accused is not then sane, or the court can question sanity without any suggestions.

The patient is brought to the hospital by one or more Deputies and taken to the Security Office. The

The Author

● Dr. Crist, Lima, Ohio, is Superintendent of Lima State Hospital.

Deputy takes the court papers to the Record Room—consisting usually of a copy of the indictment, but *always* a journal entry which shows the date, the name of the committing court, the court case number, the charge, the patient's name, sometimes the name of the defense attorney, the specific allegation, the Section of the General Code violated, and the Section covering the commitment. The journal entry is examined carefully, and if correct, the Deputy then takes the patient to the Admissions Suite of four rooms, where the record is started by the admissions supervisor. Valuables and clothing are checked and verified by the patient, if the mental condition allows.

The patient is measured; weighed; photographed; fingerprinted; given a physical examination by the admitting psychiatrist who records the initial psychiatric interview; urine and blood specimens are obtained; the patient is examined again for vermin; given a shower, a bathrobe and goes out the door into the admissions ward, if the examining doctor or psychiatrist does not find some physical illness that would warrant admission to the acutely ill hospital or to the tuberculosis isolation ward. If there is a history of head injury or convulsive seizures, the

*Presented at The 1966 Fall Meeting of the Ohio Psychiatric Association, October 28, 1966, Akron, Ohio.

admitting psychiatrist orders a skull series x-ray and electroencephalogram.

Record Room Procedure

In the meantime, the admitting clerk in the Record Room makes out Notice of Admission slips to: the Chaplain, Social Service, Psychology, Dental, X-ray and Laboratory. She types up the Admission Record Sheet and begins the hospital Summary Sheet (all state hospitals use the State Standard Medical Record). She calls the psychiatrist to whom the patient is assigned for mental examination. She mails the family questionnaire form with a letter to the closest relative or guardian.

Social Service Department uses a check-off form and within three days after admission has completed and typed the Social Service interview and has mailed letters to obtain information from schools, employers, previous hospitalizations, service records — if a veteran, Police Departments, Courts, Probation Departments, FBI, and Ohio Bureau of Criminal Investigation and Identification. Signatures are obtained for the necessary authorization for Release of Information (Standard State Form).

The Psychological Examination

The Psychology Department does a full work-up on all persons charged with: a killing, forcible rape, child molesting, arson and any other case asked for by the examining psychiatrist. The work-up is time consuming and consists of the interview and the following testing: Wechsler Adult Intelligence Scale, Revised Beta, Bender-Gestalt, Draw-A-Person, Rorschach, and sometimes, the Minnesota Multiphasic Personality Inventory (MMPI), the Thematic Apperception Test, and occasionally in a case involving a sex offense, the Blacky Pictures are used, but this is a time consuming test.

The day following admission, a dental examination and chest x-ray are done. The following laboratory work is done on each admission: Complete urinalysis, serology, complete blood count, blood urea nitrogen, blood sugar 2-hours postprandial; a Papanicolaou smear is done on all female admissions.

If some medical or surgical problem is apparent, the Internist, Dr. Homer Deerhake, and/or Surgeon, Dr. Robert Zarzar, is asked to see the patient. If neurological symptoms are found, the Internist is asked to do a neurological examination, and he sometimes calls the Neurological Consultants, Dr. Bernard Glass and/or Dr. Soo, to do an examination and give an opinion.

Arriving at a Diagnosis

The psychiatrist (we have 4½) sees the patient *often enough* and *long enough* to arrive at a diagnosis or classification that will stand up in court under examination and intensive cross examination. He talks with the attendants on the admission ward who are trained to observe, record and report the

conditions, progress and mood of patients. He examines all of the material that Social Service has been able to provide, and he carefully considers the report of the psychologist. If he cannot arrive at a diagnosis, we ask the court for a 30 day extension of the observation period.

Staffing Procedure

Just before the end of the observation period, the patient is called to the Staff Room after the case has been presented in detail to the Assistant Superintendent. The patient is talked to about the case and whether or not he considers himself mentally ill now or at the time of the allegation. He is asked: "Do you understand the nature of the charges to be brought against you in court? Can you cooperate with your attorney in preparing your defense? Do you know right from wrong? Is it wrong to commit a crime such as you are alleged to have done?"

Report of Examination

The diagnosis is confirmed and the following letter is sent to the Clerk of Courts, with a carbon to the prosecuting attorney, the Adult Probation Department of the county, the Department of Mental Hygiene and Correction, and the Division of Psychiatric Criminology:

"This is in reference to the above-named individual who was committed to this hospital on for thirty (30) days mental observation under Section 2945.40 R.C. Ohio. Mr. has been observed and examined intensively. He has received psychological examinations and tests. In our opinion he does *or does not* understand the nature of the charges to be brought against him and can *or cannot* counsel in his own defense. He, therefore, would be considered sane *or insane*."

On an individual basis, if requested, a full report is furnished to the Adult Probation Department of the county, the prosecuting attorney or the court.

The defense attorney can get a court order to be furnished specific information or he and the prosecuting attorney can come to the hospital together for a review of the case with the examining psychiatrist.

No stone must be left unturned — anything and everything that might be asked in court by the defense attorney, the prosecuting attorney or the court has to be considered. The defense dwells on the I. Q. and how much time was spent with the patient, how often was he seen, how often was he talked to and what was the subject of the talks. Both the defense and prosecution want a "Yes" or "No" answer as to the mental condition at the time of the alleged crime, in addition to the present mental condition. Usually, several weeks or possibly several months have lapsed between the

arrest of the patient and the time he is sent to Lima State Hospital for observation and examination.

Sometimes, there are preconceived ideas by those who have been in contact with the patient before he arrives at Lima. We cannot be of any value to any court if we allow ourselves to be guided by preconceived ideas of any person. We cannot please all of the prosecutors and the defense attorneys all of the time. We cannot build a case for either of them.

Sometimes, a person is admitted for observation who needs immediate treatment. In such cases, we ask the committing court for authority to treat and at the end of the observation period, ask the court for an immediate hearing with return of the patient the same day or no later than the following day, if long distances are involved, so that there will not be disruption of treatment.

The Ascherman Case

The second kind of case sent for examination is the person sent under the provisions of Section 2947.25, "Psychiatric examination before sentence." Under the provisions of the Ascherman Act the Court may refer for examination any person who has been convicted of any felony, except murder in the first degree where mercy has not been recommended, or any misdemeanor involving a sex offense, or in which abnormal sexual tendencies are displayed, when it has been suggested or appears to the court that such person is mentally ill, or a mentally deficient offender or a psychopathic offender. The person has been convicted and the court refers him to Lima State Hospital for not more than 60 days for a careful examination and a written report as to the mental condition of the person at the time of the examination, together with such recommendations, suggestions and opinions as may be helpful to the court. These are the Ascherman cases, and we report to the court after examination that the person, in our opinion, would or would not be considered mentally ill, or a mentally deficient offender or a psychopathic offender.

The report and such other evidence, as is submitted, are considered by the court and the appro-

priate sentence for the offense is imposed, and at the same time, the court enters an order of indefinite commitment to the Department of Mental Hygiene and Correction during the continuation of which the sentence is suspended. The time spent at Lima State Hospital is counted as time served with good behavior under the applicable sentence.

Other Procedures Available To the Court

Under Section 2945.40 in a case where insanity is set up as a defense, or in which present insanity of the accused is under investigation, the court may commit the defendant to a local hospital for the mentally ill or may appoint one or more, but not more than three, psychiatrists to investigate and examine into the mental condition of the defendant and testify as experts at the trial or other hearing.

Under Section 2947.25 "Psychiatric examination before sentence" a trial court *must refer* for examination all persons convicted under Section 2903.01, Assault upon a minor; 2905.03, Carnal knowledge of a female under 12; 2905.04, Attempt to have carnal knowledge; 2905.07, Incest; 2905.44, Sodomy. The referral is to a state facility designated by the Department of Mental Hygiene and Correction, or to a psychiatric clinic approved by the Department, or to three psychiatrists and shall be for a period of not more than 60 days.

Prior to sentence, the court *may refer* for such examination any person who has been convicted of any felony, except murder in the first degree where mercy has not been recommended, or any misdemeanor involving a sex offense, or in which abnormal sexual tendencies are displayed, when it has been suggested or appears to the court that such person is mentally ill, or a mentally deficient offender or a psychopathic offender. Everything is included from "A" — Arson to "W" — Window-peeping.

Most cases under both of the above Sections (2945.40 and 2947.25) are referred to Lima State Hospital as we are set up and geared-up to do the observations and examinations and can provide adversary tested psychiatrists for expert witnesses.

ANALYSIS OF DICTATORS has demonstrated in their personality makeup one element of great importance that they share with many other persons inclined to the use and promotion of violence: intense narcissism. Overemphasis on one's own ego leads to great vulnerability, with exaggerated reactions to real or imaginary frustrations, humiliations, or slights. On the primitive level of functioning these reactions manifest themselves above all in anger, culminating at times in rage and violence. — Gustav Bychowski, M. D., New York, N. Y.: Psychopathology of Aggression and Violence, *Bulletin New York Academy of Medicine*, 43:300-309, April 1967.

The Right to Treatment

By THE HONORABLE PAUL C. WEICK

TODAY a substantial amount of the time of the psychiatrist is devoted to the patient who may be subject to voluntary or involuntary commitment for mental illness, and to mentally ill persons who are charged with crime and ought to be treated rather than punished. More and more the psychiatrist comes into contact with lawyers and judges.

Society is concerned with the great increase in the incidence of crime in this country, with the large number of mentally ill persons, and with the grotesque and bizarre crimes which have been committed the past year. These crimes include the brutal murders of the eight nurses in Chicago, the sniper shooting in Austin, Texas, which resulted in the loss of 16 lives and 30 casualties, the rape-strangle murders in Cincinnati, and the mentally ill wife who murdered three of her six children and when released from a mental institution for a trial visit murdered her remaining three children.

It may be necessary for psychiatrists and lawmakers to formulate new procedures to cope with occurrences and recurrences of this nature.

While there has been some disagreement in the Courts and also among psychiatrists over the definition of insanity, it is settled law in this country that insanity constitutes a complete defense to a criminal charge. The conviction of an insane person violates due process.

Not only is insanity a complete defense, but a person cannot even be brought to trial for a criminal offense unless he understands the nature of the charge against him and is capable of assisting in the preparation of his defense.¹

Criminal Punishment of Persons Who Are Ill

The Supreme Court of the United States in *Robinson v. California*, 370 U.S. 660 (1962) held that a state statute which inflicted punishment on a person merely because he was ill, violated the Eighth and Fourteenth Amendments to the Constitution as constituting cruel and unusual punishment. The California statute which was invalidated made it a misdemeanor punishable by imprisonment for any

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person to "be addicted to the use of narcotics." The California Courts had construed this statute as making the "status" of narcotics addiction a criminal offense, even though the offender had never used or possessed narcotics within the state.

Mr. Justice Stewart, who wrote the opinion for the Court, said:

"In this Court counsel for the state recognized that narcotic addiction is an illness. Indeed, it is apparently an illness which may be contracted innocently or involuntarily. We hold that a state law which imprisons a person thus afflicted as a criminal, even though he has never touched any narcotic drug within the state or has been guilty of any irregular behavior there, inflicts a cruel and unusual punishment in violation of the Fourteenth Amendment. To be sure, imprisonment for ninety days is not, in the abstract, a punishment which is either cruel or unusual. But the question cannot be considered in the abstract. Even one day in prison would be a cruel and unusual punishment for the 'crime' of having a common cold." (Page 667)

Justice Stewart stated, however, that an addict could be legally confined for treatment. The *Robinson* case was the forerunner of federal appellate decisions dealing with chronic alcoholics.

(a) Chronic Alcohol Addicts

In *Driver v. Hinnant*, 356 F.2d 761 (4th Cir. 1966) the question was whether a chronic alcoholic can constitutionally be criminally convicted and sentenced for public drunkenness. The North Carolina statute provided:

"If any person shall be found drunk or intoxicated on the public highway or at any public place or meeting in any county . . . herein named, he shall be guilty of a misdemeanor."

(N.C. Gen. Stat. 14-335)

As a more than three-time repeater, Driver, who pleaded guilty, was sentenced to imprisonment for two years by a North Carolina Court.

Driver's argument in the state court was that chronic alcoholism is a disease which has destroyed the power of his will to resist the constant exces-

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1. *Pate v. Robinson*, 383 U.S. 375 (1966); *Bishop v. United States*, 350 U.S. 961 (1956).

sive consumption of alcohol; that his appearance in public in that condition is not of his own volition, but a compulsion symptomatic of the disease; and that to stigmatize him as a criminal for this act is cruel and unusual punishment.

This plea failed, and his conviction was affirmed by the Supreme Court of North Carolina. His habeas corpus petition filed in the Federal District Court was denied. On appeal of the habeas corpus proceeding to the United States Court of Appeals for the Fourth Circuit, the judgment of the District Court was reversed. The Court of Appeals pointed out that Driver was 59 years old. His first conviction for public intoxication occurred at the age of 24. Since then, he has been convicted more than 200 times. For nearly two thirds of his life he has been incarcerated for these infractions. In fact, while at large on bail pending his appeal in the present case, he was twice convicted for like violations.

The Court said that chronic alcoholism is now almost universally accepted medically as a disease. When that is the conduct for which he is criminally charged, there can be no judgment of criminal conviction passed upon him. To do so would affront the Eighth Amendment, as cruel and unusual punishment in branding him as a criminal, irrespective of consequent detention or fine.

No crime has been committed, the Court said, because his conduct was not activated by evil intent nor accompanied with a consciousness of wrongdoing, which are indispensable ingredients of crimes, citing *Morissette v. United States*, 342 U. S. 246. The Court also cited *Robinson v. California*, *supra*, as compelling the view which it took. The Court ordered Driver's release, unless within ten days the state should decide to take him into civil remedial custody. In other words, the Court held Driver could be treated, but not punished, for his illness.

In *Easter v. District of Columbia*, 361 F.2d 50 (1966), the Court of Appeals reviewed a conviction of a chronic alcoholic for public intoxication, which was made an offense by an Act of Congress. The Court based its decision reversing the judgment of conviction on its construction of another Act of Congress entitled "Rehabilitation of Alcoholics," the purpose of which was to establish a program for the rehabilitation of alcoholics, to promote temperance, and to provide for the medical, psychiatric and other treatment of alcoholics. The Court interpreted this statute as indicating a congressional intent for the treatment of chronic alcoholics rather than for punishing them for crime.

The trouble was that Congress had never implemented this statute to provide facilities for treatment of alcoholics, but the Court held that the criminal charge could not stand and would have to be dismissed. The Court cited the *Driver* case with approval and indicated that it would have reached the same conclusion without the Act of Congress

which it construed. The Court pointed out that a chronic alcoholic does not have the mens rea necessary to be held responsible criminally for being drunk in public. The Court was careful to emphasize, however, that a voluntarily intoxicated person was not absolved from criminal responsibility.

In *Sweeney v. United States*, 353 F.2d 10 (7th Cir. 1965) the Court held that a probation condition that the probationer "refrain from the use of alcoholic beverages in any form and . . . support his family to the best of his ability" is unreasonable as impossible, if psychiatric or other expert testimony was to establish that alcoholism had destroyed his power of volition and prevented his compliance with the condition.

A Court of Appeals in Michigan recently refused to adopt, as the law of that state, decisions holding it to constitute cruel and unusual punishment to sentence to prison a chronic alcoholic on a charge of drunkenness and disorderliness. In *People v. Hoy*, 143 N. W. 2d 577 (1966) the Court stated:

"While we may agree that prison is not the most appropriate place for chronic alcoholics, we are not prepared to say it is cruel and unusual punishment to place them there for their own protection as well as that of the general public."

The *Hoy* case is now pending in the Supreme Court of Michigan.

The Supreme Court of the United States has recently refused to review a decision of the Supreme Court of California in the *Budd* case, where habeas corpus had been denied a chronic alcoholic who had been convicted for public intoxication. *Budd v. California*, 35 L. W. 3139. Budd had been an alcoholic for more than 30 years and had been arrested for drunkenness or conduct while drunk 40 times. Justices Fortas and Douglas dissented from the order denying review.

In his dissenting opinion Justice Fortas pointed out that over 6,000,000 Americans are reputed to be afflicted with alcoholism, and that three out of every eight arrests are for drunkenness. He said:

"Our morality does not permit us to punish for illness. We do not impose punishment for involuntary conduct, whether the lack of volition results from 'insanity,' addiction to narcotics or from other illnesses. The use of the crude and formidable weapon of criminal punishment of the alcoholic is neither seemly nor sensible, neither purposeful nor civilized."

The fact that the Supreme Court refused to review the *Budd* case does not mean that it approves the decision, but the failure to review the case leaves the law unsettled, with two Federal Appellate Courts holding one way and two state courts holding the other way.

The Supreme Court gave no reason for denying review of the *Budd* case and we can only speculate that it was because there was agreement and no conflict in the decisions of the Federal Courts of Appeal on this subject. The Court might also have

been of the opinion that the responsibility for treatment, care, supervision, correction, and rehabilitation of chronic alcoholics should be left to the states. We cannot look to the Supreme Court to remedy all of the ills which afflict our society.

The Supreme Court is undoubtedly cognizant of the fact that some of its recent decisions reversing state court convictions have stirred bitter controversy, not only with state law enforcement agencies, but also with many men and women who believe, whether rightly or wrongly, that the balance has been weighted too much in favor of persons charged with crime, rather than for public safety. There are people who unjustly blame the Court for the current crime wave. The present public climate, however, is not conducive to persuading the Supreme Court to launch excursions into other controversial fields of state criminal law.

I do think that our professions have a duty to educate the public to regard alcohol addicts as sick people who should be treated for a disease, rather than criminally punished.

We must persuade the State Legislatures and Congress to provide the necessary funds to establish adequate facilities for their treatment and rehabilitation.

(b) Narcotic Addicts

Decisions of the Federal Courts since the *Robinson* case have held that mere addiction to narcotics is no defense to a charge of violation of the narcotics laws and does not alone constitute evidence of insanity or mental disease. In order to constitute a defense, the accused must prove more, namely, that he lacked the capacity to commit the offense. Evidence that the accused was suffering from withdrawal symptoms and was deprived of the drug at the time of the offense, would be sufficient in the District of Columbia to warrant submission of the issue of insanity to a jury.²

Rights of Mentally Ill Prisoners

In *Rouse v. Cameron*, 35 L. W. 2196 (D. C. Cir., 1966) the District of Columbia Court of Appeals, on October 10, 1966, held that a District of Columbia-criminal-defendant, who was involuntarily committed to a mental hospital, upon his acquittal by reason of insanity has the right, enforceable by habeas corpus, to adequate and suitable treatment.

The Court was construing Section 9 of the D. C. Hospitalization of the Mentally Ill Act of 1964³ which provides in part:

"Any person hospitalized in a public hospital for the mentally ill shall, during his hospitalization, be entitled to medical and psychiatric care and treatment."

The Court, in an opinion written by Chief Judge Bazelon, said that the purpose of involuntary hospitalization is treatment, not punishment, and that absent treatment, the hospital is transformed into a penitentiary where one could be held indefinitely for no convicted offense. The Court said that regardless of statutory authority, involuntary confinement without treatment is shocking.

The Court further said:

"[T]he hospital need not show that treatment will cure or improve the patient but only that there is a bona fide effort to do so. This requires the hospital to show that initial and periodic inquiries are made into the needs and conditions of the patient with a view to providing suitable treatment for him, and that the program provided is suited to his particular needs."

The Court remanded the case to the District Court for a hearing to determine whether the patient was receiving adequate treatment, and if not, the reason why not.

Judge Danaher dissented, not because the opinion on its face did not seem to be plausible, but because the Court decided a case which was not before it. Judge Danaher said that the patient was not complaining about not receiving treatment. He was complaining because he was not insane, and therefore needed no treatment and should be discharged.

The *Baxtrom* case (383 U.S. 107) held that a mentally ill prisoner, confined in an institution for the criminally insane, upon completion of his sentence was entitled to civil commitment the same as any other person, with the right to a jury trial under New York law on the issue of his mental illness; that denial would deprive him of the equal protection of the law; and that he could not be committed as a dangerous, mentally ill person without a hearing. The Court did not pass upon the right of *Baxtrom* to be represented by counsel in the civil commitment proceedings.⁴

This decision caused consternation in New York, where more than 600 inmates of institutions for the criminally insane had to be transferred to state mental hospitals.

Mandatory commitment laws are in force in about 12 states and the Virgin Islands, as well as in England and in the District of Columbia. They will undoubtedly come before the Supreme Court sometime for constitutional determination.

In federal criminal practice outside of the District of Columbia there is no provision for a plea of not guilty by reason of insanity. The jury, however, may consider the defense of insanity, but returns a verdict of guilty or not guilty of the crime charged. Legislation has been introduced in the Senate to remedy this defect so as to provide for a plea of not guilty by reason of insanity.⁵ This legislation

2. *Castle v. United States*, 347 F.2d 492 (D. C. Cir., 1964); *Heard v. United States*, 348 F.2d 43 (D. C. Cir., 1964).

3. 78 Stat. 944, Public Law 88-597.

4. In *People v. Breese*, 213 N.E. 2d 500 (Ill., 1966) the Supreme Court of Illinois held that a commitment proceeding following a term of imprisonment was civil in nature, but the prisoner was entitled to the essential protections available in a criminal trial, including the right to be represented by counsel.

5. S. B. 3753

provides for a hearing after a verdict of not guilty by reason of insanity, to determine whether the defendant would constitute a person of danger to himself or to others.

What Constitutes Insanity?

Just a few words about the definition of insanity in criminal cases. The law of Ohio on the subject has been settled for over a century.⁶ The latest expression of the Supreme Court of Ohio is found in *Stewart*⁷ case which arose in Summit County. Stewart, a young man 17½ years old, lured an 18-year old girl into his parents' home during their absence, hit her over the head with a hammer repeatedly, and then strangled her. He fled to California, where he was arrested on a vagrancy charge and was returned here for trial.

The Supreme Court held that a person accused of crime, who knows and recognizes the difference between right and wrong in respect to the crime with which he has been charged, and has the ability to choose the right and abjure the wrong, is legally sane. In Ohio every person is presumed to be sane and insanity is an affirmative defense, the burden of proving which is on the defendant, by a preponderance of the evidence.⁸ In the federal courts there is a presumption of sanity which continues until the presumption is overcome by evidence. When sufficient evidence has been offered to overcome the presumption of sanity, the burden is upon the prosecutor to prove sanity beyond a reasonable doubt.⁹

The M'Naghten rule employs what has been called the "right-wrong test" and is in force not only in England but also in most American jurisdictions as the test of criminal responsibility. Under this rule, to establish the defense of insanity,

"[I]t must be clearly proved that, at the time of the committing of the act, the accused was laboring under such a defect of reason, from disease of mind, as not to know the nature and quality of the act he was doing, or, if he did know it, that he did not know he was doing what was wrong." 8 Eng. Rep. 718, 722 (1843)

The *Durham* rule (214 F.2d 862), which was invented by the District of Columbia Court of Appeals, is simply that—

"An accused is not criminally responsible if his unlawful act was the product of mental disease or mental defect."

The *Durham* rule has not met with favor in other jurisdictions and has been roundly criticized. It has not been followed in any other Circuit, and has been applied only in the District of Columbia Circuit. Apparently it has not even worked out satisfactorily there, because it was later changed by re-defining mental disease and defect to include any abnormal condition of the mind which substantially

affects mental or emotional processes and substantially impairs behavioral controls.¹⁰

The American Law Institute's Model Penal Code has defined insanity as:

"SECTION 4.01. Mental Disease or Defect Excluding Responsibility.

1. A person is not responsible for criminal conduct if at the time of such conduct, as a result of mental disease or defect, he lacks substantial capacity to appreciate the criminality of his conduct or to conform his conduct to the requirements of the law.

2. The terms 'mental disease or defect' do not include an abnormality manifested only by repeated criminal or otherwise anti-social conduct."

This code has been followed in the Second Circuit.¹¹ So far as I can ascertain, the M'Naghten rule has been modified only in the District of Columbia,¹² Second, Third,¹³ and Tenth Circuits.¹⁴ In Wisconsin the M'Naghten rule recently was retained by a divided Supreme Court, but the defendant who pleaded not guilty by reason of insanity was given the option to be tried under the American Law Institute rule where the burden of proof to establish insanity would be on him.¹⁵

The Common Pleas Court of Cuyahoga County in the *Colby* case¹⁶ suggested that consideration be given to changing the Ohio law on insanity. This can be done only by the Legislature or the Supreme Court of Ohio. The existing rule seems to have worked out fairly well in Ohio and I doubt whether any changes will be made in the foreseeable future.

The right of the public to protection must always be considered. We must not make it too easy for a person accused of crime to be acquitted by reason of insanity and then, after commitment for a short period, allow him to go free on the claim that he has been restored to his senses, and again endanger the public.

Suppose a person charged with crime pleads not guilty by reason of insanity. He is examined by his own psychiatrist, who makes a report to his lawyer. He then refuses to submit to an examination by a psychiatrist employed by the state, and the court orders that he submit to such an examination. He refuses to obey the court's order, claiming that under the Fifth Amendment he cannot be compelled to be a witness against himself. Can he thus evade an examination by the state's psychiatrist and prevent the state from offering evidence to rebut the testimony of his own psychiatrist?

The Supreme Court of Minnesota recently decided such a case¹⁷ and held that in the absence of sta-

10. *McDonald v. United States*, 312 F.2d 847, 851 (D. C. Cir. 1962)

11. *United States v. Freeman*, 357 F.2d 606 (2d Cir. 1966)

12. *Durham v. United States*, 214 F.2d 862 (D. C. Cir., 1954)

13. *United States v. Currens*, 290 F.2d 751 (3rd Cir., 1961)

14. *Wion v. United States*, 325 F.2d 420 (10th Cir., 1963)

15. *State v. Shoffner*, 35 L. W. 2019 (Wisc., 1966)

16. *State of Ohio v. Colby*, 215 N.E.2d 65 (Ohio Com. Pleas Ct., 1966)

17. *State v. Olson*, 143 N.W. 2d 69 (Minn. 1966)

6. *Loeffner v. State of Ohio*, 10 Oh. St. 598 (1857)

7. *State of Ohio v. Stewart*, 176 Oh. St. 156 (1964)

8. *State of Ohio v. Stewart*, *supra*.

9. *Fitts v. United States*, 284 F.2d 108 (10th Cir. 1960)

tutory procedures providing for such examination, the court could not order it. The Supreme Court further held that even with statutory procedures authorizing the examination, the trial court could not order the examination if the defendant did not consent. But what good would be a defendant's consent to such an examination if he was insane? I think this decision might well be questioned. There is abundant authority to the contrary, upholding the power of the court to order an examination.¹⁸

If the defendant offers expert testimony in support of his defense, the state should have the right to examine him and prove that he is not insane. The Supreme Court of the United States has held that it does not violate the constitutional right of a defendant arrested for drunken driving, for the police to take a sample of his blood to determine its alcoholic content.¹⁹ This does not compel him to be a witness against himself. The principle of this case would seem to permit examination by the state's psychiatrist, even though the defendant does not consent. The state's psychiatrist, however, would not be permitted to testify as to any admission or statement relating to the crime.

Irresistible Impulse Defense Not Favored in Ohio

The defense of irresistible impulse has not met with favor in Ohio. It has been held here not to constitute a defense unless the defendant does not know the difference between right and wrong.²⁰ Irresistible impulse has, however, been recognized as a defense in many of the Federal Circuit Courts, including our own.²¹

In conclusion, as a former United States District Judge for Northern Ohio, I would like to say that one of the most difficult and disturbing duties of the trial judge is that of sentencing the criminal offender. We realize that our guides are not adequate, and frequently we are uncertain of the wisdom of what we have done.

Sentencing of Criminal Offenders

The time honored theory of sentencing is not only to punish the criminal offender, but also to

deter others. We sometimes wonder how well this theory works in actual practice. We know that confinement, particularly for a long time, can produce a hardened criminal and recidivist. The frequency of crimes committed indicates that fear of punishment does not operate as much of a deterrent. We must therefore devise new procedures.

Sentencing Institutes for the instruction of both federal and state judges are being held in various parts of the country. Crime and sentencing procedures are under study by a Commission appointed by the President, the Judicial Conference of the United States, and the American Bar Association.

Dr. Melvin Heller addressed a sentencing institute conducted by the Crime Commission of Philadelphia. He was of the view that the rehabilitation potential of our disposition of offenders should be carefully examined. He discussed ways and means in which legal process and behavioral science can be brought to work together more effectively. He emphasized that psychiatry

"... has collected, systematized and organized an extensive series of direct observations of human behavior from birth to death and has developed ideas and theories which seek to explain the motivation and meaning of that behavior,"

and that psychiatry was —

"... often able to demonstrate the continuing influence of childhood experience in the personality and day to day behavior of the adult and draw inferences with respect to prediction or prognosis, in a general way."²²

Dr. Heller made concrete proposals for the criminal court's own clinic, in which the Judge would be the clinician in chief. If these clinics could be established they would be of great assistance to the sentencing Judge in enabling him to select the type of discipline best suited for the individual's rehabilitation.

The psychiatrist can contribute much to the sentencing judge, parole boards, and penal institutions, in evaluating and classifying criminal offenders, and in prescribing for their treatment. We can only hope that many of the current investigations and proposals will result in new criminal procedures which will rehabilitate the criminal and reduce the incidence of crime.

18. 8 Wigmore on Evidence (McNaughton Rev.) § 2365;

Early v. Tinsley, 286 F. 2d 1 (10th Cir., 1960)

19. *Schmerber v. California*, 34 L. W. 4586 (1966)

20. *State v. Ross*, 92 Ohio App. 29

21. *United States v. Pollard*, 282 F. 2d 450 (6th Cir. 1960);
285 F. 2d 81 (6th Cir. 1960).

22. 40 F. R. D. 419

MEDICINE consists of science, wisdom, and technology. We teach the science; we ignore the study of human behavior from which wisdom could derive; and we profess to despise technology though we see it all around us. — Sir Robert Platt, B.T., M.D., M.SC., F.R.C.P., F.G.G.P.: Thoughts on Teaching Medicine, *British Medical Journal* 2:551-552, September 4, 1965.

Psychiatric Emergencies and the State Hospital System in Cleveland

NORMAN A. CLEMENS, M.D.

THE PATIENTS who come to the psychiatric emergency service of a large general hospital present a wide variety of acute disposition problems. A significant number require immediate hospitalization to avert suicide or homicide, to stop behavior that is out of control, or to treat psychoses while they are in their most acute, dangerous, and reversible stages. Many patients present a very confusing clinical picture which is hard to evaluate during an initial single visit. Early hospital observation helps greatly to clarify the nature of the problem, the risks, and what must be done.

Any delay in hospitalization increases the risk of violence or of losing contact with the patient. It also prolongs his suffering and increases the adverse effects of his illness upon his family, particularly the children.

The adult psychiatric emergency service of the University Hospitals of Cleveland is operated on a 24-hour basis by second and third year psychiatric residents under the supervision of staff psychiatrists. It serves the population of Cuyahoga, Lake, and Geauga counties, with a predominance of patients from Cleveland and the eastern suburbs. In 1964 it performed 1354 emergency evaluations, out of a total of 2945 recorded by all emergency services in Cuyahoga, Lake, and Geauga counties.¹

For many years the residents have reported frequent instances of major difficulty in arranging a disposition for acutely disturbed emergency patients, particularly within the state hospital system. While there has been substantial improvement in the past 15 years, numerous unfortunate incidents still occur. In order to document the current nature, extent, and frequency of these problems, a questionnaire was filled out by the residents on all adult emergency evaluations done during the 30 days of November, 1966. The results are the subject of this report.

A focus on difficulties with the state hospitals comes about naturally in such a study. By the time a state hospital is called to admit the usual patient, he is already a selected case. Either he is indigent

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or he has been denied a bed in the private psychiatric units, because they are full. The state hospital system is the final resource called when the others cannot meet the need. When the patient is refused here also, a "disposition problem" makes itself known.

Method

The month of November was a random selection not based upon any expected variations in the results.

The questionnaire was constructed in two parts. The first part was filled out on all patients and gave identifying data, the time of day, the lengths of time required for diagnosis and to arrange disposition, and the presenting diagnosis from the nomenclature of the American Psychiatric Association.² The resident also checked whether or not there was a suicidal risk or a homicidal risk and whether the patient was "out of control." Probable risks of violence were checked "yes" along with the clear-cut ones. As a number of patients present multiple risks, the categories of risk were not mutually exclusive.

The phrase, "out of control," in the questionnaire was interpreted by each resident as it applied to the case at hand; it usually implies behavior which, because of a psychic disturbance, the patient is powerless to stop or conduct wisely (such as using alcohol or drugs, spending money, sexual activities, aggressiveness, etc.).

The resident then indicated whether "adequate care" of this patient would require hospitalization, by checking one of the alternatives, "immediately," "electively," or "no." A further question asked if he considered immediate hospitalization at a state hospital essential for the patient; if the answer was yes, the second part of the ques-

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tionnaire was to be filled out. The final disposition of the patient was stated.

The second part of the questionnaire dealt with the contacts with the state hospitals: whether difficulty was encountered, if so what kind of difficulty and what hospital, and what alternative arrangements had to be made if the patient was refused direct transfer to a state hospital. The resident then gave "yes" or "no" answers to the questions, "Did you feel that proper care of the patient was compromised by difficulties with the state hospital system?" and, "Did excessive time spent arranging a disposition in this case interfere with your other duties?"

In the analysis of the data the patient was included in the "psychotic" group if his diagnosis was in the psychotic portion of the nomenclature. Thus, all schizophrenics were considered psychotic, as were those with manic-depressive psychosis, acute brain syndrome with psychosis, etc.

Results

A total of 153 emergency evaluations were done during November. Hospitalization was not indicated for 81 of these patients, and elective hospitalization was indicated for 23. In order to provide adequate care, immediate hospitalization was sought for 49 patients.

In 18 of these 49 cases, disposition at a facility other than a state hospital was appropriate and realistic. In the remaining 31 cases, direct admission to a state hospital was considered essential because the patient was indigent or sometimes because there were no beds available in private hospitals.

Among the 31 patients for whom a state hospital was contacted by the resident on call to arrange admission, seven were admitted to state hospitals without difficulty and two left the emergency room against medical advice after admission had been arranged. In the remaining 22 cases the resident encountered difficulty in setting up a suitable disposition in the state hospital system.

Characteristics of the 22 Problem Cases

The nature of the various kinds of difficulty is presented in Table 1. Most notable is the fact that the hospital first called (the one serving the patient's residence district) did not have an available bed in 15 cases, and in nine of these cases further calls failed to find an open bed in any of the four state hospitals in Cleveland. The other major category

TABLE 1. *Difficulty with State Hospital Disposition*

Nature of Difficulty	No. of Patients
No beds in the hospital serving patient's residence district	15
No beds in any state hospital (this group is also included in the preceding group)	9
Refusal to accept patient until the following morning	5
Refusal to accept patient until five hours later	2
Undue delay in dealing with the resident's request	5

N. B. Some patients had difficulty in more than one category.

of difficulty was delay either in accepting the patient or in dealing with the resident's request.

Among these 22 patients, 12 were thought to have a suicidal risk, six to present a risk of homicide, 11 to be psychotic, 10 out of control, and one in opiate withdrawal.

The final disposition of the 22 patients, as they left our emergency room, is stated in Table 2. Eight were admitted to state hospitals. Two were admitted

TABLE 2. *Final Disposition of 22 Problem Cases*

Disposition	No. of Patients
Admitted to state hospital in residence district	4
Admitted to state hospital in another district	4
Admitted to Hanna Pavilion above census and without hospitalization insurance	2
Jail	1
Home with close supervision to await further arrangements	11

to the psychiatric divisions of University Hospitals. One went to jail and 11 were returned to their homes.

In sum, 14 patients were refused by state hospitals, out of 31 requests for direct admission. For seven, no arrangement at all could be made with a state hospital. In the other seven cases a bed was promised by a state hospital the next morning or (if available) within a day or two, but various problems of interim care had to be dealt with by the resident, the patient, and the family.

The person sent to jail, following medical evaluation, was diagnosed as acute and chronic alcoholism and suicide attempt. A state hospital agreed to take the patient the next day.

The two people admitted to University Hospitals were placed on psychiatric divisions above the maximum census; neither patient had hospitalization insurance or the means to pay the hospital bill. One was transferred to a state hospital a day later. The other, an adolescent girl, remained 14 days before transfer to a state hospital could be carried out.

Among the 11 people sent home with close supervision, seven were suicidal, four were psychotic, three were out of control, one was in opiate withdrawal, and none was thought to be homicidal. Three of the patients sent home had state hospital beds promised to them for the next morning, and two others were waiting for beds which were expected to open up within 24 to 48 hours. For the remaining six, no arrangements of any kind could be made.

In 15 cases, the resident indicated that he felt that proper care of the patient had been compromised by difficulties with the state hospital system. Most of these were acutely disturbed people who had to be sent home.

In 10 cases, the resident stated that excessive time spent arranging a disposition in this case had interfered with his performance of other duties (e.g., seeing other emergency patients). In nine cases

TABLE 3. *High-Risk Characteristics of Disposition Groups*

Type of Disposition Indicated	No.	Suicidal Risk	Homicidal Risk	Psychosis	Loss of Control
Immediate Hospitalization at State Hospital	31	18	10	17	16
Immediate Hospitalization in Other Facilities	18	8	7	12	10
Elective Hospitalization	23	4	1	8	2
No Hospitalization	81	12	4	3	6
Total	153	42	22	40	34

N. B. Some patients had findings in more than one of the above categories.

TABLE 4. *Indicated Disposition and Final Disposition*

Type of Disposition Indicated	No.	Hospitalized in State Hospital	Hospitalized Elsewhere	Home Against Medical Advice	Home	Jail
Immediate Hospitalization at State Hospital	31	15	2	2	11	1
Immediate Hospitalization in Other Facilities	18		14	1	3	
Elective Hospitalization	23				23	
No Hospitalization	81		1*		80	
Total	153	15	17	3	117	1

*Patient was admitted when he returned to emergency ward eight hours after being sent home.

TABLE 5. *Time Required for Disposition*

Type of Disposition Indicated	No.	More than One Hour to Arrange Disposition	Excessive Time Interfered with Other Duties
Immediate Hospitalization at State Hospital	31	11	11
Immediate Hospitalization in Other Facilities	18	3	1*
Elective Hospitalization	23	1	0*
No Hospitalization	81	0	0*

*Results may be incomplete because of the design of the questionnaire.

(not necessarily the same), the resident spent over an hour arranging a disposition. A range of 1.5 to 12 hours in this group was reported, with a mean of 4.2 hours. In one situation, the resident counted 13 phone calls, in another 14 phone calls to various facilities as he tried to work something out.

The residents commented in a number of cases that they were treated very courteously and that extensive efforts had been made by the hospital first called to find a bed elsewhere if they had none available. In only two cases were the hospitals described as uncooperative.

It was the residents' general impression that this had been an unusually good month for getting patients into state hospitals without difficulty.

Characteristics of Other Groups

Seven patients were admitted to state hospitals without difficulty. In two other cases, admission was arranged with ease but the patient then left the emergency room against medical advice. Of this group of nine, six patients presented a suicidal risk and four a homicidal risk, six were out of control, and six were psychotic. Disposition took more than one hour in two cases (2 and 3 hours respectively) but interfered with other duties in only one case (one hour).

Among the 18 patients for whom immediate hospitalization was sought at places other than the state hospital system, 10 were admitted to the psychiatric service and three to other services in

University Hospitals. One went to a V.A. hospital (after considerable difficulty) and four went home (one against medical advice and three for the waiting list, commitment proceedings, and/or subsequent evaluation for state hospital admission). Eight were considered suicidal, seven homicidal, and 10 out of control. Twelve were psychotic. Disposition took over an hour in three cases.

In the group of 23 people for whom elective hospitalization was indicated, there were four with a suicidal risk, one with a homicidal risk, and two who were out of control. Eight had diagnoses which were presumed to indicate psychosis. In only one case did disposition take over one hour. All went home to await hospital arrangements or to return later for further evaluation.

There were 81 people who, according to the residents' judgment, did not need to be in a hospital. These included a number of people with some risk present, but the residents tried to manage them as outpatients by maintaining continuing contact. Twelve presented a suicidal risk and four a homicidal risk. (One of the latter was admitted to University Hospitals when he returned eight hours later.) Six were out of control and three carried psychotic diagnoses. Disposition of all cases took less than one hour.

Table 3 summarizes the high-risk characteristics of the various disposition groups, and Table 4 compares the indicated dispositions with the final dispositions. Table 5 summarizes the cases in which

disposition arrangements took longer than one hour or interfered with the residents' other duties.

Discussion

The outstanding finding of this study is that out of 31 patients in one month for whom immediate, emergency admission to a state hospital was sought, 14 were turned away. There is plainly a serious lack of beds available at Cleveland's four state hospitals for the reception of acutely disturbed patients.

Several of the unfortunate effects of this situation are suggested by the other findings described above. An alcoholic woman who had just attempted suicide was sent to jail, a common site for suicide. Eleven other people who were suicidal, psychotic, out of control, or in drug withdrawal had to be sent back to their homes. This strikes one as a poor way to start to work at reducing the rate of successful suicides. (In Cuyahoga County in 1966 the number of suicides was 197, which exceeded homicides, 165, and rivalled traffic deaths, 204, as a cause of death.³)

When this gamble could not possibly be taken, two other patients were admitted to University Hospitals' psychiatric divisions above the maximum census at rates which they could not afford. This happens with distressing frequency: during 1966 there were approximately 24 people admitted to the psychiatric service of University Hospitals without insurance, awaiting disposition. One was admitted twice during the year. They stayed an average of five to six days—some for a day or two, some for two or three weeks. Public welfare funds may be used to pay for up to 48 hours of emergency psychiatric care in a general hospital, at a rate substantially less than the hospital cost; they may not be used for more extended psychiatric care. Since 14 of these admissions during 1966 were longer than two days, these patients were left with an additional burden of a debt in the hundreds of dollars. The hospital is frequently unable to collect any reimbursement, with a resultant drain on hospital resources.

To admit these acute emergency patients is consistent with the University Hospitals' policy of accepting any patient who legitimately needs admission whenever there is room. Most of them would contribute well to the teaching and research functions of the hospital. It is unfortunate that the present untenable financial situation causes these worthwhile admissions to be turned into a hardship for both patient and hospital.

Since the questionnaire did not distinguish between varying degrees of severity of risk or clinical state, and since the interpretation of these terms was left to the individual resident involved in each case, there is no way to be sure how many of these patients were genuinely dangerous. It would appear from Table 3 that the residents were able to distinguish a certain number in each risk group who could be managed on an outpatient basis or with elective hospitalization.

This leads to the assumption that the people for whom the residents chose to seek immediate hospitalization were the more serious cases.

May it not also be asked whether it is fair to the residents, who have had only a year or two of clinical experience in psychiatry, to ask them to assume responsibility for these judgments without assuring them available beds for the patients they find most dangerous?

The heavy demands placed upon the residents' time by the contacts with state hospitals are also worthy of mention (see Table 5). On an emergency service handling an average of three to five and sometimes up to 10 psychiatric emergencies daily, spending four hours arranging a disposition for a single patient becomes very disruptive. It is unclear why it should take so long, but two major factors seem to be (1) the shortage of personnel in the state hospitals to handle emergency situations, and (2) difficulties in communication and coordination between the various state hospitals. Much telephone time is consumed in waiting for key admissions people to be summoned, to check with their superiors, or to go through the same delays themselves in contacting other state hospitals. Repeated efforts have failed to help our own residents improve the directness and speed of the referral process.

In the instances where the state hospitals have refused to accept patients until hours later or the next morning, serious problems have arisen in regard to where to keep the patient and how to handle the medical responsibility for his care during the interim period. In our hospital the patient is often placed on one of the psychiatric divisions to wait, but the patient and the staff are both placed at a disadvantage by the lack of formal admission procedures and the patient's status as an extraneous responsibility. Occasionally, very disturbed patients have escaped from our emergency room when kept there awaiting transfer to a state hospital. A neighboring hospital has been forced to tie up one of its 10 emergency room cubicles for as long as 24 to 36 hours with a waiting patient. When patients are sent home to wait, families are legitimately anxious about whether they can again induce the patient to go with them to a hospital—this time a state hospital—and medical contact with the patient is sometimes lost. While the patient is waiting at home, his additional anxiety may increase the pressure toward violence. All of these alternatives are time-consuming for the resident and tense for everybody.

Obviously, emergency psychiatric hospital care in Cleveland depends heavily upon the state hospital system, especially for the indigent patient. Indigent psychiatric patients with serious complicating medical or surgical problems can often be admitted to other services in the general hospitals, where welfare funds may be available to defray the expense. But when the state hospital refuses the indigent patient with an

acute, purely psychiatric illness, the patient has no other place to turn. No psychiatric hospital, state or private, should have to overcrowd itself, and hence reduce the quality of care, to deal with these urgent needs. Since the state system has a clearly stated legal obligation to accept emergency patients, it is not meeting its medical and legal responsibilities when it does not have adequately staffed emergency beds available on a 24-hour basis. Any measures to improve the situation would have to take into account the many patients who have no funds and no hospitalization insurance.

How representative of the usual experience are these observations? There is no way to establish this at present, although computer methods are being instituted on the emergency service which will make future studies of our own work possible. According to the subjective impression of the residents, this was a typical if not better than average month for such problems on our emergency service. The neighboring hospital previously mentioned, which runs a large emergency service, has had numerous similar experiences, and instances elsewhere in Cleveland have come to our attention. Whether the problem exists in this form state-wide or is particular to the Cleveland area is not certain. However, casual inquiry among psychiatrists in other large cities in Ohio indicates that emergency referrals to state hospitals are accomplished with much less difficulty in other areas than in Cleveland.

Summary

Disposition problems among acute psychiatric emergencies were the subject of a questionnaire sur-

vey covering a 30-day experience in a general hospital emergency ward in Cleveland. Out of 153 emergency evaluations done, 49 patients required immediate hospitalization to provide adequate care.

Out of 31 cases in which state hospitals were contacted to arrange immediate admission, 14 patients were refused. Eleven of these patients had to be returned to their homes despite suicidal risks, psychosis, out-of-control behavior, and/or opiate withdrawal. One other went to a jail.

Only nine of the 31 state hospital requests were handled without difficulty of some sort. Problems in the other 22 cases were the absence of beds in state hospitals, refusal to accept the patient until the next morning or hours later, and long delays in completing arrangements which often interfered with the residents' performance of other duties. In 15 cases it was felt by the resident that proper care of the patient had been compromised by these difficulties.

A severe shortage of beds and personnel to handle emergency cases in the state hospitals is postulated as the major cause of this situation.

I am grateful to the residents for their outstanding cooperation, to Dr. John B. Sawyer, Chief Resident in Psychiatry, for his assistance in handling the questionnaire and compiling certain other data, and to Dr. J. P. Duffy for his comments and advice.

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"INSANITY" of GEORGE III. — This study allows the certain conclusion that George III's malady was not "mental" in the accepted sense, in whatever old or modern terms it may be couched. His long and sorrowful illness in which he suffered severely from his affliction, pitifully from his treatments, and miserably from his management, takes on a new importance in the annals of medical history as the first description of a rare metabolic disorder not even today fully understood. Moreover, the royal malady is unique for the continuity of its documentation over 58 years — indeed, in the last illness four of the physicians who had attended the king in earlier attacks had been replaced by their sons.

The assumption that the king was "neurotic" will also have to be revised, since porphyria may render its victim restless, hurried, agitated, and impulsive, especially in minor attacks which go unrecognized. Finally, by implication this diagnosis clears the House of Hanover of an hereditary taint of madness imputed to it by the long-sustained but erroneous interpretation of George III's illness. — Ida Macalpine, M.D., and Richard Hunter, M.D., London, England: *British Medical Journal*, 1:65-71, January 8, 1966.

Ocular Ochronosis with Alkaptonuria

Report of a Case

SANFORD HIMMEL, M.D., and NELSON ADELSTEIN, M.D.

THE FIRST reported case of dark urine or alkaptonuria was by Scribonius in 1584. The name ochronosis was coined by Virchow in 1866 because of the ocher-yellow color of the connective tissue at necropsy, and refers to the condition in which there is cartilage, skin, or scleral pigment deposition derived mostly from polymerized homogentisic acid.¹ Ochronosis is inherited in most cases as a recessive with an incidence in the general population of less than one in a million. The sex distribution is about equal.

The alkaptonuria is the result of homogentisic acid in the urine, which, when alkalinized by the addition of sodium hydroxide or spontaneously by the formation of urea from bacterial action, assumes a dark brown color. Alkaptonuria itself simply means a substance in the urine which has an affinity for alkali and is by itself asymptomatic.²

Ochronosis has also been reported with the use of phenols and with the handling of quinones over a long period.³

Case Report

A 61-year-old white man was admitted to the hospital because of the finding of peculiar pigmentation of unknown etiology which he claimed to have had for 30 years (Fig. 1). His psychiatric diagnosis was chronic brain syndrome with cerebral arteriosclerosis with a psychotic reaction. His parents were first cousins.

Physical findings revealed a grade 2/4 systolic murmur at the apex, a left scrotal hydrocele, moderate generalized cardiac enlargement, deforming arthritis of the right knee, and a questionable bulge of the prostate, in addition to his eye findings. His visual acuity was corrected in each eye to 20/20. There was pigmentation present in a triangular



FIG. 1. Bilateral demonstration of ochronotic pigment deposition.

shape with the base toward the limbus and located within the palpebral aperture 2 to 3 mm. behind the limbus and anterior to all four horizontal rectus muscle insertions. The pigmented area did not transilluminate. There was no strabismus. By slit lamp, a dark brownish-black pig-

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ment was seen to be present intrasclerally. The rest of the external, slit lamp, and internal examinations were normal. Tonometry in the right eye was Schiotz 14.6/5.5, and in the left eye was 15.9/5.5.

His urine specimens showed a trace to 4 plus sugar with negative acetone readings by the use of Clinistix® tablets, but the same urines tested with Clinistix® were invariably negative for sugar. Fasting blood sugars and two hour postprandial blood sugar determinations were all within the normal range for the laboratory. His urines were pale yellow to straw colored, and all determinations had a specific gravity between 1.005 and 1.009. On standing overnight or immediately following the addition of sodium hydroxide, the urine would turn dark and a dark brown precipitate would form at the bottom. When this urine was spilled on exposed photographic film, the urine-covered area turned black. Electrolytes, uric acid, alkaline phosphatase, total protein, blood urea nitrogen, and creatinine were all within normal limits. The blood count parameters were all normal except for an increase in the polymorphonuclear leukocytes, which returned to normal following treatment of a mild urinary tract infection as evidenced by less than six white cells per high power field in the urine sediment.

X-rays showed marked degenerative changes to be present in all of the visualized intervertebral disc spaces, with calcium present in several of the narrowed joint spaces. Apparent bony ankylosis following complete destruction of the right sacro-iliac joint was present.

He was taken to surgery where the sclera in the area of the right lateral rectus muscle was biopsied. Pathologically, large deposits of coarse brown pigment were seen.

Discussion

The clinical features of ochronosis with alkaptonuria are a darkening of the urine by alkalization; pigmentation, which usually starts in the second or third decade and involves the sclera and the cartilage of the ears early and then progresses to the skin of the face, the superficial tendons, and the cartilages of the trachea and larynx; and osteoarthritis of the intervertebral discs.⁴

The scleral staining is usually bilateral and usually affects the exposed portions nasal and temporal to

the cornea. The sclera is the most common area of the eye involved though the cornea may also be involved.

Pigment deposits seem to occur mostly in:

1. tissues undergoing mechanical stress like joints, tendons, heart valves, and arteries;
2. endocrine or exocrine gland cells or in cells concerned with secretion or elimination of body wastes such as kidney tubular epithelium, apocrine, and ceruminous glands;
3. collagenous and cartilaginous tissue, where vascularity is minimal and where metabolism is sluggish, such as dura mater, cartilage, tendons, and fingernails. Light does not seem to affect deposition.⁵

Pigmentation is especially prominent at the bases of the mitral and aortic valves.³

The biochemical defect is the lack of homogentisic acid oxidase, thereby preventing the breakdown of the benzene ring of homogentisic acid and so interfering with the complete metabolism of tyrosine to CO₂ and H₂O. Homogentisic acid is a reducing agent and gives a positive reaction to testing tablets, which determine the presence or absence of reducing substance by the Benedict copper reaction. However, it gives a negative sugar reading when tested with the Clinistix since this determines the presence or absence only of glucose.¹ Homogentisic acid is chemically related to photographic developing agents. The Fishberg test, which is specific for homogentisic acid, takes advantage of this. Strongly alkalized urine, when dropped on sensitized photo-

graphic film, immediately turns it black in the presence of homogentisic acid. Conditions such as porphyria, hepatic disease, myoglobin and hemoglobin diseases, hematuria, and melanuria may produce a dark urine, but homogentisic acid is the only compound found in urine which will give a positive reaction in the Fishberg test.⁴

The mechanism of pigment deposition seems to be first a reversible physical binding between the connective tissue macromolecules and homogentisic acid, followed by an irreversible chemical binding of homogentisic acid polymers.¹ In some areas it seems as if the pigment deposition alters the physical properties of the tissues, while in areas like the dura and kidney, it seems to act directly by producing necrosis.⁵

Summary

The characteristics of alkaptonuria with ochronosis are: (1) a history of passing dark urine with confirmation by the Fishberg test; (2) pigmentation, especially of the ears and sclera; (3) early osteoarthritis and ochronotic spondylitis; (4) abnormal urine Benedict reaction with a negative true glucose.

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THE USE OF CONTACT LENSES by industrial workers sometimes compounds eye hazards already associated with certain jobs. Such use should alert industrial physicians to the need for emphasizing careful eye hygiene, repeated visual examination, and systematic recording of pertinent findings. The wearing of contact lenses is contraindicated in certain jobs that require critical emergency action or that expose the worker to unusual hazard of injury to the eyes. The job placement of each applicant who wears contact lenses must be determined only after thorough evaluation of job hazards and visual needs. Contact lenses are not in themselves protective devices and in fact may increase the degree of injury to the eyes. The same eye-protective devices used by other workers should be worn by contact lens wearers in similar employment. — From an Official Report of the AMA Council on Occupational Health. *The Journal of the American Medical Association*, 188:397, April 27, 1964.

A Baedeker for Fat-Controlled Diets

VI. Oils, Margarines, and Other Processed Foods

HELEN B. BROWN, Ph.D.,* and MARILYN FARRAND, M.S.†

TRADITIONALLY, fat is closely associated with fine food. French "Cordon Bleu" cooking depends on skillful use of heavy cream and butter. Prime rib roast and porterhouse steak are regarded the most succulent meats. By contrast, fat-controlled menus are considered uninteresting. However, foods prepared with vegetable oils can still retain the appetizing quality of fat.

Polyunsaturated fatty acids lower blood cholesterol levels⁵; vegetable oils containing 50 per cent or more polyunsaturates are eminently suitable for the vegetable oil food pattern.^{4,7} Edible oils of this composition are cottonseed, corn, soy, and safflower (Table 3). Safflower oil is the most unsaturated; it contains 60 to 70 per cent polyunsaturates. Unfortunately, to prevent deterioration soy oil has to be hydrogenated, a process which decreases the polyunsaturated fatty acid content. Coconut oil and cocoa butter are almost completely saturated. Nut oils, except walnut, are high in monounsaturated fatty acids, which do not affect blood cholesterol levels. Therefore, peanut and olive oils do not contribute substantially to the supply of dietary polyunsaturated fatty acids, yet may be used to give variety and flavor to the menu.

Commonly available vegetable oils are cottonseed, corn, and safflower. They may be used for baking, frying and flavoring, in addition to their customary use in salads. Most commercially prepared salad dressings, including mayonnaise, may be used in the vegetable-oil food pattern; they are usually made with cottonseed oil, occasionally with corn and safflower oils. The small amount of egg yolk in mayonnaise does not change its fatty acid composition appreciably and contributes only 8 mg cholesterol per tablespoon.

In addition to these highly unsaturated oils, certain special margarines made from them may be used. Guidelines for purchasing these highly un-

saturated margarines are difficult to formulate. Those made of liquid corn or safflower oil and soft enough to require packaging in a tub or can are best. They are 40 to 60 per cent polyunsaturated. Less unsaturated margarines, those with only 28 to 40 per cent polyunsaturated fatty acids, are firm enough to be made into sticks or prints, but some may be packaged in tubs, also. Their labels usually state they contain safflower or corn oil with partially hydrogenated or hardened safflower, corn or soy oil. Since these labels and advertising confuse the consumer, dietitians should recommend certain brands based upon manufacturers' information.

Ordinary margarines and the usual solid shortenings do not contribute sufficient polyunsaturated fat for use in the vegetable-oil food pattern, for they contain only 10 to 20 per cent polyunsaturates. Identification of these products is easier than the special margarines. The label on ordinary margarines states they are made chiefly from partially hydrogenated soy or cottonseed oil; they are packaged in print form.

Polyunsaturated margarines are used in baking, frying and seasoning, just like ordinary margarines and shortenings. By blending them with dry cottage cheese, one can make a delicious "cream cheese," and by adding buttermilk to this mixture, an excellent "sour cream."

The amount of vegetable oil prescribed depends upon the calorie level of the diet.⁷ If 35 to 40 per cent of the calories are to be provided by fat, the calorie level and the amount of oil are as follows: 1500 calories (Cal.) — 3 tablespoons (T); 1900 Cal. — 4 T; 2200 Cal. — 5 T; 2600 Cal. — 6 T; 2900 Cal. — 7 T. If only 25 to 30 per cent calories are prescribed, two-thirds these amounts of oil are advised. In order to assure adequate amounts of polyunsaturates in this latter prescription, the most unsaturated oil, safflower, should be used. In these food patterns, mayonnaise and margarine may be substituted for equal amounts of oil. Two tablespoons salad dressing or 3 tablespoons French Dressing are equal in fat content to one tablespoon oil.

Thus far, the basic food choices for fat-controlled diets have been reviewed — meats, fruits and vege-

The Heart Page is a periodic feature of *The Journal* containing brief, practical comments on subjects of immediate importance to practicing physicians. The comments are solicited by the Professional Education Committee of the Ohio State Heart Association.—Ed.

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tables, cereals and sweets (Article 5), and vegetable oils and their products. Food choices are easy when the fat composition of these basic foods is understood. However, markets have a wealth of processed foods, such as mixes, fully prepared frozen entrees, baked goods, processed meat specialties and ready-to-cook items of all kinds. To select foods from this variety, the products used in their manufacture must be known. The kind and amount of fat they contain may be inferred from the label on which ingredients are listed in descending order of content. For instance, a coffee cream substitute is labeled as follows: vegetable fat, corn syrup solids, sodium caseinate, sodium citrate, carrogeenin, sorbitan monostearate, polysorbate 60, pure carotene, water. This label indicates that the product is high in fat, mainly vegetable fat. It leads one to believe it is suitable for the vegetable oil food pattern. However, the kind of vegetable fat is also important. Since the product is powdered and kept without refrigeration, the fat is probably coconut oil, a highly saturated fat; under these storage conditions, unsaturated oils would become rancid quickly. Unfortunately, this cream substitute is not suitable.

Many low-fat products suitable for all fat-controlled diets may be identified from information on the label. For example, ingredients in a loaf of wheat bread are listed as follows: flour, water, whole wheat flour, brown sugar, shortening, yeast, salt, yeast food, caramel coloring. Shortening, or fat, is listed after the main ingredients just before yeast and flavorings, so it may be assumed that the fat content

of bread is minimal. A typical analysis of bread indicates that a slice contains 0.5 to 0.7 grams fat. In this case of a very low fat product, the type of fat is relatively unimportant.

By using these guidelines, consumers can find many low-fat processed foods in the market. These include a large variety of cereal products, such as ordinary breads and rolls, soda crackers, spaghetti; soups, pancake and biscuit mixes; sauce and gravy mixes; entrees like Spanish rice and vegetarian baked beans; desserts, such as pudding mixes, angel food cake with boiled frosting, and a few packaged cookies, such as fig bars, arrowroot cookies and ginger snaps; and a large array of sweets, jellies, syrups and candies.

By being aware of the fat content of basic foods and their use in preparing interesting and attractive meals, consumers can modify their fat intake. The marketing trend is toward "convenience" foods. If the fat content were modified by the manufacturer, fat-controlled diets could be achieved with less effort. For example, foods with minimum fat, such as trimmed lean meats, could be produced for use in diets low in all fats. Products such as baked goods and various entrees could be made with highly unsaturated fats for those whose diets require them.⁸ These modifications are indispensable if the general public is expected to follow fat-controlled diets.

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CARDIAC NONDISEASE. — Of 20,500 schoolchildren surveyed to determine the number falsely considered to have heart disease (cardiac nondisease) and the possible effects of this on them, 93 were reported at one time to have heart disease or rheumatic fever; heart disease was present in 18 per cent. Of the 75 children with no current heart disease, 30 (40 per cent) were judged to be restricted in some way — six severely.

Most of the unnecessary restriction was due to the physician's advice. Lay confusion about heart disease in children, specifically, fear of heart attacks from overexertion, played a major contributory part.

The amount of disability from cardiac nondisease in children is estimated to be greater than that due to actual heart disease. — Abraham B. Bergman, M. D., and Stanley J. Stamm, M. D., Seattle, Washington: *The New England Journal of Medicine*, 276:1008-1013, May 4, 1967.

Electrocardiographic-Pathologic Conference

Right Bundle Branch Block and Ventricular Hypertrophy

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THE clinical-pathological conference (CPC) has long been a popular and instructive teaching session in most medical centers. A similar type of approach to electrocardiographic analysis has been most interesting and informative in the experience of the author. Such an electrocardiographic-pathologic conference (EPC) is now presented.

The electrocardiogram is interpreted by the electrocardiographer without knowledge of either the clinical or pathologic findings. The clinical findings are then presented and the electrocardiographer may then modify or further amplify his report. Finally, the necropsy findings are presented, followed by a brief summary and correlation.

Electrocardiographic Interpretation (Fig. 1)

The P-R interval is 0.24 sec., indicating first degree atrioventricular (AV) block. The QRS is 0.12 sec. and there is an rSR' pattern in V₁. The R' is wide measuring 0.10 sec. The height of R' is 18 mm.; the onset of the intrinsicoid deflection of R' is 0.11 sec. There are broad S waves in lead I and

in the left precordial leads. These findings are consistent with right bundle branch block (RBBB). A definite electrocardiographic diagnosis of right ventricular hypertrophy (RVH) cannot be made from this tracing, although it may be suspected by inference.

The R wave in V₅ is 27 mm.; the tall R in the left precordial leads in the presence of right bundle branch block is suggestive of left ventricular hypertrophy (LVH). The P waves are notched in lead II with a duration of 0.10 sec. There is a conspicuous negative deflection in V₁ but it does not measure 0.04 sec. in duration and scarcely 1 mm. in depth. The possibility of left atrial enlargement (LAE), however, must be considered.

Summary:

- (1) Probable LVH
- (2) Possible RVH
- (3) Complete RBBB
- (4) Possible LAE
- (5) First degree AV block

Remarks:

Barker and Valencia¹ proposed that a secondary R wave in V₁ in complete RBBB of 15 mm. or greater was indicative of associated RVH. In autopsy con-

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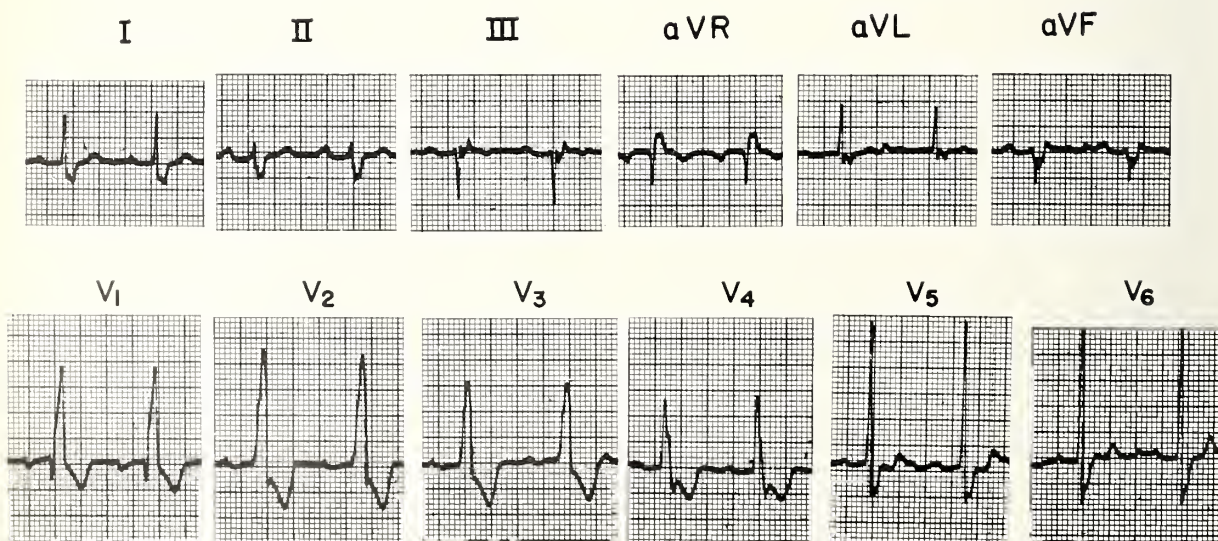


FIG. 1. Electrocardiogram recorded on June 4, 1965. This tracing exhibits first degree AV block and complete right bundle branch block. The tall R waves in the left precordial leads are suggestive of associated left ventricular hypertrophy. (See text for full discussion.)

trolled studies from this laboratory we have found this criterion not especially helpful.^{2, 3} In this particular case only an inferential diagnosis of RVH can be made. The presence of relatively tall R waves in the left precordial leads in the presence of RBBB suggests the existence of associated LVH. It is important to take into account the patient's body build. If the patient is thin or emaciated, high voltage in the left precordial leads may lead to a false positive diagnosis.

Clinical Resumé

This 85 year old Negro woman was known to have had hypertension for at least 17 years. She had been followed at the Cincinnati General Hospital for hypertension, coronary artery disease, and congestive heart failure for about 10 years. In the clinic her complaints were usually of mild dyspnea, intermittent chest pain, chronic joint pains, and, on her last clinic visit on July 12, 1965, right sided weakness.

On July 30, 1965, she was admitted to the hospital with a complaint of severe chest pain associated with marked dyspnea. An electrocardiogram recorded on 7/30/65 was similar to the tracing shown in Figure 1, except that second degree AV block was now present. This was thought to be due to digitalis intoxication and appropriate therapy was begun. She continued, however, to complain of dyspnea and of pain in the epigastric region.

The chest x-ray showed the long-standing cardiomegaly and in addition a sharp cut-off of the right pulmonary artery.

She died on her third hospital day.

Necropsy Findings

At autopsy, the habitus of this 85 year old woman was slender; the body length was 63" and the weight was 115 pounds. The Ponderal Index was 12.96.⁴ The heart weighed 420 grams, indicating moderate hypertrophy according to the criteria of Zeek.⁵ After removal of the epicardial soft tissues the heart weighed 260 grams. The absolute weight and percentage of total cardiac weight represented by epicardial tissues was unusually high. There was mild right ventricular dilatation and mild endocardial sclerosis was evident in the outflow tracts of both ventricles. The thickness of the lateral left ventricular wall, measured 2 cm. below the AV groove, was 18 mm. The thickness of the anterior right ventricular free wall, measured 1 cm. below the level of the pulmonary valve in the outflow tract, was 6 mm. The mass of the left ventricular free wall plus septum (LV+S) was 169 Gm., which in a woman is a borderline value, suggestive of mild left ventricular hypertrophy.⁶ The ratio of left ventricular free wall plus sep-

tum/right ventricular free wall (LV+S/RV) was 1.85, which is unusually low (normal range 2.1—3.6), indicating the presence of preponderant right ventricular hypertrophy.⁶ The right ventricular free wall weight was 91 Gm. compared to 65 Gm., the maximum normal value observed in women.⁶ Atrial weights were normal and approximated each other. The coronary arteries exhibited moderate atheromatous changes, but no areas of severe narrowing or occlusion were detected. The myocardium was grossly and microscopically normal. Multiple large and small pulmonary emboli in varying stages of organization were responsible for the right ventricular hypertrophy.

Comments

This case illustrates some of the diagnostic problems encountered in the electrocardiographic diagnosis of ventricular hypertrophy in the presence of RBBB. The conventional electrocardiographic criteria for the diagnosis of RVH in the presence of RBBB are not very reliable as noted above. The presence of concomitant LVH may often be masked by RBBB.⁷ On the other hand, associated LVH in the presence of RBBB may be suspected if the voltage in the left precordial leads is increased. Ordinarily in RBBB without LVH the R wave voltage in the left precordial leads is not increased unless the patient is thin. In this case, even though the patient was slender, the increase in voltage in V₅ and V₆ was probably at least in part due to associated LVH.

The author wishes to express his thanks to Dr. Kevin E. Bove, who performed the detailed necropsy examination in this case, and to Dr. Robert J. Norris and Dr. Emmett Conyers for their participation in the electrocardiographic and clinical correlation.

This article is the first of a regular, quarterly, feature in *The Journal*, presented through the cooperation of the author and the Ohio State Heart Association. — Ed.

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A Clinicopathological Conference

From The Ohio State University Hospital, Columbus, Ohio

Edited Under the Auspices of the Ohio Society of Pathologists

PAUL N. JOLLY, M.D., *President*

PRESENTATION OF CASE

A FIFTY-SEVEN YEAR OLD white laborer was admitted to Ohio State University Hospital with the chief complaint of "seizures." Except for mild diabetes, controlled with oral hypoglycemic agents for the two years prior to admission, the patient had been in good health. One month prior to admission fever, malaise, and myalgia developed. This influenza-like illness persisted for approximately one week, and he then became completely asymptomatic and remained so until 10 days prior to admission, when he again felt weak and tired and also very sleepy. His family observed that he had some inappropriate behavior, such as sitting in the laundry basket. He had persistent, sometimes throbbing, right temporal and frontal headaches, relieved incompletely by aspirin.

When these symptoms became worse, he was admitted to a local hospital. On the first hospital day he had grand mal seizures occurring every 20 minutes for six hours. They finally subsided after Dilantin® and barbiturate medication. The patient had a slight fever. The next day he was transferred to University Hospital for more definitive evaluation of the seizures and the right frontoparietal headaches.

The past history was not remarkable except for the mild diabetes he had had for four years, treated in the past two years with Diabinese®. The family history revealed that a sister had died of a brain tumor at this hospital one year prior to the patient's admission here.

Physical Examination

The patient was well developed, heavy, and lethargic but responded to deep, painful stimuli. The blood pressure was 90/50, pulse rate 100 per minute, respiratory rate 34 per min., and temperature 99.6°F. rectally. Examination of the head, eyes, ears, nose and throat revealed no abnormalities except for a possible right visual field defect by the confrontation test. The left field appeared to be normal, and there

Presented by

- H. M. Friedman, M.D., Columbus, and
 - F. E. Cuppage, M.D., Columbus;
- Edited by Dr. Cuppage.

was no papilledema. The carotid pulsations were normal, and although the neck was not completely supple, movements could be elicited without causing pain. The diameter of the chest was increased and a prolonged expiratory phase was present. Examination of the heart and of the abdomen revealed no abnormalities. The neurological examination revealed the patient to be lethargic and disoriented. He reacted appropriately to painful stimuli. The cranial nerves appeared to be intact except for a questionable loss of the right visual field. There was no motor deficit. Due to the patient's condition, sensory examination was incomplete; however, superficial reflexes were absent. Babinski responses were elicited bilaterally. The remainder of the physical examination revealed no abnormalities.

Laboratory Data

Laboratory studies at the time of admission disclosed the following values: hemoglobin 16.4 Gm./100 ml., 33,500 leukocytes per cu.mm. with 93 per cent neutrophils and 6 per cent lymphocytes; blood sugar 183 mg./100 ml.; blood urea nitrogen (BUN) 22 mg./100 ml.; sodium 145 mEq./liter, chloride 97 mEq., potassium 5.9 mEq., and CO₂ combining power 23 mEq. A lumbar puncture performed the following day was reported to show an opening pressure of 190 mm. of water. The spinal fluid was clear and colorless, with 2 red blood cells and 2 white blood cells per cu.mm., 158 mg. of sugar per 100 ml. (concomitant blood sugar 215 mg.), and 66 mg. of protein per 100 ml.

An electroencephalogram showed an epileptogenic focus in the right frontal lobe. A tracing obtained while the patient was having a seizure showed

Submitted April 14, 1967.

medium and high voltage 5 per second spikes with more frequent low voltage spikes and sharp waves. Following the seizures there was a general depression of all electrical activity lasting approximately 20 seconds before the periodic shock-wave activity resumed. There were bursts noted which arose in the right frontal area. An echo-encephalogram performed on the first hospital day showed a 3 mm. shift to the left. This was repeated the next day and showed a shift of less than 1 mm. to the left. A right brachial arteriogram revealed good filling of the vertebral and carotid systems. The x-ray was read as being within normal limits. A chest film subsequently showed a density in the right lower lobe, thought most likely to represent an area of pneumonia. An electrocardiogram showed left axis deviation, and the precordial transition zone was uncrossed.

Other studies which were performed early in his hospitalization and revealed normal values were arterial lactate and pyruvate levels, urinalysis, urine and spinal fluid cultures, serum glutamic pyruvic transaminase (SGPT), albumin/globulin ratio, latex fixations, serology, serum calcium, prothrombin, alkaline phosphatase, and arterial pH. The serum glutamic oxalacetic transaminase (SGOT) was 100 units, the lactic dehydrogenase (LDH) 940 units. A moderate growth of coagulase-positive *Staphylococcus* was obtained from sputum.

Hospital Course

A right brachial angiogram showed no mass lesion. Although the patient had a few seizures after hospitalization, these were controlled with Dilantin and phenobarbital. The seizures were described as generalized, although one observer noted a seizure which began on the left side and then progressed to a generalized one. Approximately three days after his admission the patient was still afebrile; he was oriented and read the newspaper. His white blood cell count had dropped to 18,500 without specific therapy. However, his blood sugar rose to 215 mg., the BUN to 52 mg., and the creatinine to 4.5 mg./100 ml. The following day the patient had a fever of 103.5° and became lethargic. A chest film showed a right lower lobe infiltrate. Methicillin and streptomycin were begun. The patient was also started on insulin to control his hyperglycemia. On the fifth hospital day the blood sugar was 338, the BUN 72, and the creatinine 3.6 mg. The sodium was 156, chloride 117, and potassium 5.4 mEq. His white blood count had again risen to 30,500. It was noted that the patient had cyanosis, asterixis, and rales in both bases.

On the sixth hospital day the patient had an episode of acute hypotension followed by emesis and aspiration into his trachea. Steroids were now started and methicillin and streptomycin were continued. A second urinalysis showed many white blood cells and therefore Chloromycetin® was started because

of the possibility that the hypotension was due to a gram-negative sepsis. Although the patient's blood sugar had risen to 970 mg. and his sodium was 166 mEq., there were no ketones in the blood or urine. He was treated with large amounts of hypotonic fluids and high doses of insulin, and he was also given Aramine® to support the blood pressure. After he had received 13 liters of hypotonic fluid in about 36 hours, the nonketotic hyperglycemic state had been corrected but the patient remained semicomatose. His neurologic status otherwise did not change except that the Babinski signs were irregularly present.

A lumbar puncture on the ninth hospital day revealed an opening pressure of 190 and closing pressure of 160 mm. of water. The fluid was slightly xanthochromic; it contained 330 red blood cells and 3 white blood cells, 247 mg. of sugar (concomitant blood sugar 444 mg.), and 40 mg. of protein. Since the *Staphylococcus* grown from the sputum was sensitive to methicillin and chloramphenicol, this therapy was continued. The patient was later put on a respirator. He continued to do poorly.

On the 12th hospital day a repeat electroencephalogram showed high voltage or polyphasic slow-wave discharges which were interpreted as being consistent with severe cortical damage. Later that day, hypotension and coma worsened and the patient died in spite of resuscitative efforts.

CLINICAL DISCUSSION

DR. FRIEDMAN: I think the case today is an interesting one with a multiplicity of problems. We are faced with the differential diagnosis in a 57-year-old diabetic whose initial neurological symptoms were inappropriate behavior. This behavior appeared before any focal complaints whatsoever, and it occurred on a background of a very vague upper respiratory illness one month prior to admission here. In fact, the upper respiratory illness cleared completely about 10 days prior to the onset of this inappropriate behavior. Subsequently this man had some focal signs which consisted of a throbbing right-sided headache and he had the onset of generalized seizures, and in fact what sounds like an episode of status epilepticus. That is, for a period of six hours he had generalized seizures occurring every 20 minutes and I would expect that he probably did not regain consciousness in the interval. This was treated with anticonvulsants and subsided. A mild fever also was noted. These are essentially the complaints which he had over the two weeks prior to the admission here.

Now on his examination we attempt to look for some neurological abnormalities that will give us an idea of the anatomical location of the lesion responsible for his symptoms, and here again we see first of all some generalized findings, namely, that he was lethargic but responded to deep, painful stimuli. I would suspect that this was more than lethargy. I would rather refer to this man's difficulty as stupor

or quite deep obtundation. In addition he had some abnormalities in his general vital signs—tachycardia, increased respirations, and a borderline blood pressure.

Neurologically, we have the possibility of a right visual field defect. Here again we have a sign which if true would lead to a suspicion that the left hemisphere was involved, whereas prior to this time, with the focal right-sided headaches, we would suspect a focal lesion on the right side of his brain. In addition he had bilateral extensor plantars, which would again invoke involvement of both sides of his brain. So we have considerable evidence here for a diffuse involvement of the brain as opposed to a strictly focal lesion.

Vascular Disease

On a background of diabetes in this age group, the most likely etiology for the seizures would be vascular disease or infarction of the brain with secondary seizures. I think there is little in the protocol to support this. We don't have any history whatsoever of transient ischemic attacks, and there is little evidence in the subsequent laboratory findings to invoke a hemorrhage into the brain. I would point out that the more likely etiology for central nervous system disease in diabetes is of course occlusive infarction as opposed to hemorrhagic infarction. Tumor is always in the differential diagnosis in a patient like this, but here again I think the background of the vague upper respiratory illness and the progress of this illness over a period of several weeks would speak against tumor.

Rather, I think, we should turn to the diseases that are associated with infection. The most important would be of course a bacterial meningitis. The most common form of headache that you see in bacterial meningitis is a diffuse nonspecific headache as opposed to a focal headache. Seizures are certainly common enough in bacterial meningitis, but status epilepticus is probably relatively uncommon. The examination of the spinal fluid subsequently I think is against a bacterial meningitis. I realize that bacterial meningitis can appear with an acellular spinal fluid, particularly in the pneumococcal and staphylococcal meningitides, but I would point out that this man improved over a period of three days, without specific therapy, to the point that he was sitting up in bed reading, and I think that this would be extremely uncommon in bacterial meningitis.

It is noted that this man had various contrast procedures done to him, and the next bacterial etiology I would like to invoke as a possibility would be subdural empyema. Subdural empyema occurs with focal headaches. It occurs usually with a very rapid onset, is associated with infections in the paranasal sinuses or on an otitic basis. I think, however, that the relatively slow course that this man showed from the onset of his illness, and again the very

rapid subsiding of symptoms in the first part of his illness, would not be compatible with this particular diagnosis.

Brain abscess, on the other hand, can certainly do this. Brain abscess can occur after any kind of primary illness. It is usually associated with infection in paranasal sinuses or in the ears, but metastatic brain abscesses from lung disease are quite common; in other words, chronic bronchiectasis or things like this are very common as etiologies for brain abscess, and I think that the initial part of this man's illness is certainly compatible with this diagnosis. We do have some contrast procedures which do not suggest this diagnosis. In addition the recovery from his initial illness without any particular therapy I think would be against a brain abscess. As you know, a brain abscess can be treated in this day and age with antibiotics and the patients can do quite well albeit the ultimate treatment is surgical. The surgery can be deferred until the abscess becomes encapsulated and the condition of the patient warrants this approach.

Viral Encephalitis

I think, however, that the onset of his illness with a diffuse symptom such as inappropriate behavior plus his bilateral signs would lead me more into the group of viral illnesses or postinfectious encephalomyelitis. Of all the viral encephalitides, without a history of exposure to any particular viral illness, without any history of a specific epidemic at the time—such as one of the equine viruses—I think that the most likely virus in this patient would be a herpes simplex. Herpes simplex encephalitis statistically, excluding the epidemics, has been noted to be the most common cause of encephalitis in the state of Massachusetts. I am not sure whether that indicates that the ability in that particular state to culture these viruses is better, but I think that this virus very commonly presents with disorders involving behavior and at times this can be so severe as to be mistaken for either delirium tremens or a toxic encephalopathy.

Confusion, inappropriate behavior, memory loss, and delirium are extremely common with herpes simplex encephalitis. I would expect, however, with this illness to have some cells in the spinal fluid, and I would not expect this illness to resolve over a period of three days so that the patient would be eating well and sitting up in bed. This disorder oftentimes is associated with seizures and presents as a focal mass lesion particularly involving the temporal lobe. Pressure in these patients is markedly increased. I think the initial part of this illness is most compatible with a postinfectious encephalitis. This disease occurs after almost any one of the many viral illnesses that are seen in childhood. It may occur as an acute fulminating disorder or it may occur several weeks after the very vague viral illness.

It usually presents with headaches. Seizures are not uncommon at all, and albeit these patients may be desperately ill to the point of being comatose, on the respirator, and decerebrate, within 48 to 72 hours they may be well enough to go home from the hospital. These patients can have a most remarkable recovery from this disease.

The initial laboratory data on this patient are quite interesting. First of all, we have almost a normal spinal fluid; the pressure is normal, the fluid is clear and colorless, and there are two red cells and two white cells. I would point out that the statement that there were two white cells is meaningless. If these were two lymphocytes, this would be normal; if these were two polys, this is grossly abnormal. I would not accept any polys in spinal fluid. I think that polys are pus until proven otherwise. The sugar is elevated, as is the protein. In all of the disorders that I have mentioned thus far I would expect some cellular response in the spinal fluid. About the only one that we think of as an acellular disease of the spinal fluid is brain abscess. Yet I would point out that in several large series the majority of brain abscesses in addition have cellular responses in spinal fluid. Other laboratory data are supportive. One is an EEG that shows a right frontal lobe focal abnormality, and an echo-encephalogram which was performed on the first day of hospitalization showed a 3 mm. shift to the left. I suspect that it was probably at that time that the angiogram was done. Will Dr. Harris please describe these studies?

Radiologist's Discussion

DR. HARRIS: The chest x-rays show some widening and shift to the left of the aorta which is at least partly due to some dilatation. Of interest is an infiltration with some loss of volume in the right lower lobe, and you can just faintly delineate what looks like a rounded density in the hilum which in itself is of questionable significance, possibly a small tumor or possibly a large lymph node. Enlarged lymph nodes with infection are rather uncommon in adults and it does make you wonder.

In the arterial phase of the right brachial angiogram, there is considerable stretching of some of the vessels; however, on actual measurement there is no displacement of the anterior cerebrals and there is definitely no displacement of the middle cerebral group in any direction. On the lateral view you have the impression that the posterior cerebrals may be depressed, which is sometimes seen with uncal herniation. However, the anterior choroidal remains in normal position and this mitigates against this diagnosis. In conclusion, this is to all intents and purposes a normal right brachial arteriogram. There is an infiltration in the right lower lobe and a questionable node or small mass in the right hilum.

DR. FRIEDMAN: Following this man's angiogram he had a few seizures and then subsequently im-

proved remarkably. However, then something else happened to him. Approximately three days after he was hospitalized it is noted that his BUN, which was normal previously, had become elevated, his blood sugar stayed elevated, his creatinine went up, and he became hyperthermic. I suspect that much of this was attributed to his right lower lobe infiltrate which as I read the protocol sounded like a pneumonitis, but it is apparent that this was not a pneumonitis.

On the fifth hospital day we have even more remarkable findings in that his blood sugar had risen to 338, his BUN was up, plus other evidence of abnormalities of electrolytes. His white count had gone up to 30,000, and it is noted that he had cyanosis and asterixis with rales in both lung bases. Asterixis, commonly referred to as liver flap, is an unequivocal sign of a metabolic encephalopathy. We have the patient extend his hands at the wrists and in the initial phases there may be slight tremulousness. With the fingers abducted, however, there will be a sudden sharp fall at the metacarpophalangeal joints and in addition there may be some lateral movements of the fingers. This is seen with metabolic encephalopathies. The only other illness in which I could find it reported was subdural empyema, and this was attributed to a toxic infectious component of the subdural empyema. Therefore I suspect that at this time the patient had his asterixis and his change attributed probably to the cyanosis superimposed upon pulmonary emphysema and pulmonary encephalopathy. However, he subsequently had an episode of acute hypotension with aspiration, and because of white cells in his urine was treated with antibiotics for the possibility of gram-negative sepsis.

It appears to me that the real culprit emerges in that this man's sugar had risen to 970 and his sodium was 166 without evidence of ketoacidosis. In diabetics the most common cause of coma is diabetic ketoacidosis. I think it is obvious that this did not exist here. Diabetic lactic acidosis may occur. Here again normal arterial lactates and pyruvates I think rule this out.

Hyperglycemic Nonketotic Coma

There is a disorder known as hyperglycemic nonketotic coma in diabetics which usually occurs in elderly, mild or occult diabetics. The usual symptoms are polydipsia, polyuria, polyphagia, and some concomitant weight loss. However, the majority of cases that have been reported with this particular disorder have presented on the background of some upper respiratory illness, and the most common laboratory findings are marked hyperglycemia, usually over 1,000 mg. per 100 ml., no ketones in plasma or urine, hypernatremia, and markedly severe dehydration. These patients may in fact present in shock. This disorders is usually treated with very high doses of insulin and large amounts of fluids, ranging between 10 and 15 liters within

the first 24 hours. Despite the fact that it is a treatable illness, there is still between 40 and 50 per cent mortality.

Seizures have not been emphasized in this illness, but in 1965 seven cases from New York with focal seizures and seizures having a generalized onset were reported. The coma and seizures are usually attributed to the marked hyperosmolality of the serum with shift of water from brain cells with marked intracellular dehydration. This entity is often associated with pyelonephritis and fatty metamorphosis of the liver. I think that this man unequivocally presented with this particular syndrome and I think that probably this is the thing that did him in.

My diagnosis in this man would be a postinfectious encephalitis with hyperglycemic nonketoacidotic coma, probable acute pyelonephritis, and possible metamorphosis of the liver.

General Clinical Discussion

DR. FOLK: I agree with the diagnosis of nonketoacidosis. I don't know why these people are nonketotic. They tend to be the milder type of diabetic. Perhaps they have enough insulin that they are shutting off some of their fatty acid release and therefore do not become ketotic on this basis. I don't know why you say that it "did him in," however. It looks like it occurred on about the seventh hospital day and was fairly well treated over a 36-hour period.

DR. SCHIEVE: What do the brains show in this entity?

DR. FRIEDMAN: On a couple of occasions there have been small infarctions of brain but nothing at all specific. There have been no lesions of the hypothalamus. In fact, there was one case report of a man who presented with a temperature of 108 with hyperglycemia and no pathology at all was seen in his brain.

CLINICAL DIAGNOSIS

1. Postinfectious encephalitis.
2. Hyperglycemic nonketoacidotic coma.
3. Pyelonephritis.

PATHOLOGICAL DIAGNOSIS

1. Diabetes mellitus.
2. Hyperglycemic nonketoacidosis.
3. Diabetic encephalopathy.
4. Multifocal acute encephalitis with abscesses.
5. Aspiration pneumonia, acute.

DISCUSSION OF PATHOLOGY

DR. CUPPAGE: This is essentially a case of widespread infection in a patient with diabetes mellitus. The patient did indeed have an acute tracheobronchitis and a focal bilateral pneumonia. The areas of pneumonia were small. They involved many of the small bronchioles. Some of these bronchioles contained material which was probably aspirated substances. There is a note on the protocol that this

patient aspirated a day or so before he died. We have no direct evidence of the old bronchopneumonia, which we have interpreted as having cleared by this time. He also had cystitis of the urinary bladder. I would guess that this was the site from which a good percentage of the white cells in the urine were derived. This is a typical response not only in a diabetic but in anybody who has an indwelling catheter.

The main infection in this patient was in the brain. Multifocal areas of abscesses measuring up to 1 cm. or so in diameter were found throughout the cerebral and cerebellar hemispheres. Focal acute meningitis was overlying the right frontoparietal lobes. The abscesses were relatively acute. So we have evidence of widespread infection, and I think probably the most important diagnosis other than diabetes is that of multifocal abscesses of the brain, or, if you will, encephalitis.

In addition he had some of the other complications of diabetes. One of these was the multiple thrombi in various organs that we find so frequently in the diabetic patient. Diabetics have a tendency to clot more readily. A small recent thrombus was identified in one of the pulmonary arteries. In addition to the lung, there were thrombi in both renal veins without completely occluding them. Also there was an abscess underneath the capsule in one of the kidneys, perhaps an additional site of origin of the pyuria.

The etiology of the renal failure is difficult to explain. The kidneys contained no diabetic glomerulosclerosis. The hyperemia associated with the partial renal vein thromboses would probably not be enough in itself. It is likely that this was a prerenal failure, perhaps associated with hypertonicity.

Another interesting, and perhaps incidental, finding in this case was the presence of lipid droplets within the pulmonary capillaries. In 1963 there was a report of the association of thromboemboli in diabetics with poor control and hyperlipemia.¹ In diabetics who are under poor control there is a tendency to clot, and, in the presence of high serum lipids, to also have fat emboli. This did not likely play a significant role in the death of this patient, however.

There were indeed fatty metamorphosis of the liver and intramuscular deposition of glycogen, also often associated with diabetes mellitus. The pancreatic acinar tissue was atrophic with fatty infiltration without much atrophy of the islets. The islets were essentially normal by hematoxylin-eosin staining. Relatively normal numbers of beta granules were visualized by the Gomori strain.

So we have a patient with diabetes who developed infection and died with multifocal cerebral encephalitis, overlying cerebral meningitis, with multiple thrombi throughout the body. I would like to ask

Dr. Liss to comment on the correlation of the neurologic findings with the pathology in this patient.

DR. LISS: In addition to the acute inflammatory areas there were areas of malacia without any evidence of inflammatory disease, suggestive of long-standing vascular ischemia. Some of the abscesses were surrounded by a solid wall of gitter cells. We may perhaps assume that we have an infectious process within an area of preëxisting malacia, which is extremely susceptible to any infection. Some areas of considerable perivascular fibrosis were present and these were active as evidenced by the finding of

occasional mitoses. Tremendous gliosis had developed over a much longer period of time than just the last few weeks. It had to have been present for at least years, and we have to assume that we have to a certain degree an asymptomatic case of diabetic encephalopathy with periods of ischemia and quite a lot of widespread damage to the brain, on top of which came the infection which resulted in this multifocal encephalitis.

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(b). The entire text including case reports and lists of references should be typed double or triple space with margins of at least one inch on all sides.

(c). Tables, charts, and figures (illustrations) should be submitted separately from the text. They should be identified by number and by a concise, descriptive title. In the text, reference to them should be made by number, e. g. (Fig. 1). We shall place the figure as close as possible to this reference in the printed text.

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"2. Doe, J., and Roe, R. X.: How to Go About It. *Ohio State M. J.*, 13:24-30 (Feb.) 1920."

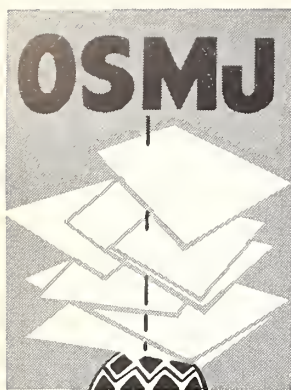
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"5. Osler, W.: *Modern Medicine*, ed. 3, Philadelphia, Lea & Febiger, 1927, vol. 5, p. 66."

8. **Identification of Patients.** Names, initials, hospital numbers, or any other identifiable labels, should not be used. It is preferable to identify patients for the purpose of publication by the use of numbers in series for the study being reported.

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NEWS AND *Organization Section*

Proceedings of The Council ...

Following Are Minutes of Two Meetings, April 11 and May 19;
Including Reports of Matters Considered and Actions Taken

MEETING OF APRIL 11

A MEETING of The Council of the Ohio State Medical Association was held Tuesday, April 11, 1967, at the Mayflower Hotel, Washington, D. C. Those present were: Drs. Lawrence C. Meredith, Elyria, President; Robert E. Howard, Cincinnati, President-Elect; Henry A. Crawford, Cleveland, Past President; Philip B. Hardyman, Columbus, Treasurer; Paul N. Ivins, Hamilton; Theodore L. Light, Dayton; Robert N. Smith, Toledo; P. John Robeck, Cleveland; Sanford Press, Steubenville; Robert C. Beardsley, Zanesville; William R. Schultz, Wooster, District Councilors.

Others attending the meeting were: Dr. John H. Budd, Cleveland, chairman, Ohio delegation to the AMA; Dr. Robert E. Tschantz, Canton, OSMA Past President, H. W. Porterfield, Columbus, Chairman, OSMA Committee on Government Medical Care; W. Dorner, Jr., Akron; Stanley M. Miller, Hamilton; the following members of the OSMA Committee on Legislation: Drs. James T. Stephens, Oberlin; Chester H. Allen, Portsmouth; Donald R. Brumley, Findlay; Jonathan G. Busby, Columbus; Jack L. Kraker, Lancaster; Maurice F. Lieber, Canton; James C. McLarnan, Mt. Vernon; Wesley J. Pignolet, Willoughby; William W. Trostel, Piqua; and Messrs. Page, Edgar, Traphagan, and Campbell of the OSMA Headquarters Office.

Ohio Bond Commission and Reapportionment

The Council voted OSMA support of State Issue No. 1, which creates an Ohio Bond Commission, and State Issue No. 2 on reapportionment of the Ohio

General Assembly. These issues will be voted on at the primary election May 2, 1967.

Clinical Laboratory Legislation

Brought up for further consideration was an issue before The Council on March 18 and 19, namely, that of adopting a policy on proposed legislation to license directors of clinical laboratories and inspection and licensing of laboratory facilities. The Council voted that such legislation, to meet the approval of the Ohio State Medical Association, must place the licensure and inspection of laboratory facilities as well as the licensing of personnel in the Ohio State Medical Board.

Committee Reports

Maternal Health

Minutes of the April 2 meeting of the Committee on Maternal Health were presented. The minutes were approved, including the committee's recommendation that The Council approve proposed regulation HE-7-08.01 of the Ohio Sanitary Code to authorize the admission of noninfectious gynecologic patients to obstetric beds in maternity hospitals. The Council authorized members of the Committee on Maternal Health to appear in support of the regulation at the public hearing scheduled by the Ohio Public Health Council on May 20, 1967.

Eye Care

The Council received the minutes of the meeting of the Committee on Eye Care on April 2, 1967. The Council approved the recommendation of the

committee that anticipated proposals to redefine optometry and relating to the appointment of "school optometrists" be opposed by the Ohio State Medical Association. In addition, Council approved the suggestion of the committee that it reaffirm its opposition to the licensing of opticians if such legislation is proposed.

The Council amended a statement of the committee and approved it to read as follows: "that a nurse or technician may add anesthetic drops to the eye and use a Schiottz's tonometer on the cornea, if such procedure is under the direction and supervision of a physician . . . that it is appropriate to have a nurse or technician perform the Glaucoma test when these personnel have been trained by a physician and act under the direct supervision of a physician."

Approved by The Council was the expression that an optometrist may not perform the Schiottz's test for Glaucoma and that this is prohibited under Sec. 4725.01 of the Ohio General Code and by the fact that optometrists are not permitted to use medication.

The final paragraph of the report dealing with Glaucoma screening programs was re-referred to the Committee on Eye Care for reconsideration and a restatement.

Nursing

Minutes of the meeting of the Committee on Nursing held March 29, 1967, were presented. The minutes were accepted, which included the approval of a resolution on the training of nurses to be presented to the OSMA House of Delegates.

Nursing Education

"WHEREAS, The National League for Nursing estimates there will be a shortage of 350,000 registered nurses by 1970, and

"WHEREAS, The American Nurses Association's 'Position Paper' on nursing education casts unverified doubts on the quality of nursing education in hospital-based diploma nursing programs which produce over 80 per cent of the nation's bedside nurses, and

"WHEREAS, The ANA Position Paper infers that diploma schools should be closed, and

"WHEREAS, The closing of hospital-based diploma programs would compound the acute shortage of bedside nurses, now THEREFORE BE IT

"RESOLVED, That efforts be made to identify and utilize financial resources in support of these schools, and BE IT FURTHER

"RESOLVED, That this Association oppose the ANA 'Position Paper' on nursing education as tending to decrease the enrollment in diploma programs by casting doubt on their quality and efficacy, and BE IT FURTHER

"RESOLVED, That the Ohio Delegation to the American Medical Association is hereby instructed

to present and support a similar resolution at the 1967 Annual Meeting of the AMA."

AMA Resolution

The Council adopted the following resolution for submission to the House of Delegates of the American Medical Association:

State PAC and AMPAC Support

"WHEREAS, The American Medical Association has previously endorsed the establishment of an independent, voluntary, nonprofit and bipartisan organization to promote political education and political action known as the American Medical Political Action Committee, AMPAC, and

"WHEREAS, In all fifty states and the District of Columbia, independent, nonprofit, nonpartisan, voluntary and unincorporated political action committees have been formed, and

"WHEREAS, Membership in AMPAC and state Political Action Committees is open to physicians, their wives and friends, and

"WHEREAS, Physician activity in 1966 culminated in an all time high of individual political participation across the country with encouraging results, and

"WHEREAS, It is essential to continue preparation for 1968 by supporting state PAC-AMPAC membership programs and by participation in political education projects, and

"WHEREAS, The American Medical Association recognizes that leadership at all levels of medicine must make individual commitment to state PAC-AMPAC membership and programs, now THEREFORE BE IT

"RESOLVED, That this House of Delegates reaffirm its support of AMPAC and the individual state PACs, and BE IT FURTHER

"RESOLVED, That the members of this House of Delegates urge the leaders and membership of their local organizations to continue their support of their own state PAC organization and AMPAC and to demonstrate their support by a membership contribution and participation in local PAC programs."

Two other proposed resolutions, one on American Medical Association unity and another on health foundations, were referred to the following subcommittee for further drafting: Dr. T. L. Light, Dayton, chairman; Dr. John H. Budd, Cleveland; Dr. Philip B. Hardyman, Columbus, and Mr. Hart F. Page, OSMA Executive Secretary.

Highway Safety Act

A communication from Dr. Wendell A. Butcher, Columbus, recommending that the responsibility for emergency care and transportation of those injured on highways be assigned to the Ohio Department of Health rather than the State Highway Department,

was considered by The Council. Dr. Butcher indicated that the AMA Committee on Emergency Medical Service is recommending to the Governor of Ohio that the Ohio State Medical Association be consulted for advice and leadership in this program so that hospital emergency room physicians may have medical association guidance. Dr. Butcher's recommendations were approved by The Council.

Harrison Community Health Center

The proposal for a Harrison County Community Health Center, which was disapproved at the meeting of The Council on March 18-19, was brought up by Dr. Press. Dr. Press indicated that this project now meets the qualifications established by The Council on March 18-19 for Appalachia and other government programs. The eight qualifications established at the March 18-19 meeting of The Council were read and each was subsequently discussed by Dr. Press, at which time he indicated that the proposal in Harrison County had met each respective test for the completion of the procedure. The Council voted approval to the Harrison County proposal.

There being no further business, The Council adjourned.

Attest: HART F. PAGE
Executive Secretary

MEETING OF MAY 19

A special meeting of The Council of the Ohio State Medical Association was held Friday, May 19, 1967, at the Sheraton-Columbus Hotel, following the final session of the House of Delegates during the 1967 Annual Meeting. The following were in attendance: Drs. Robert E. Howard, Cincinnati, President; Theodore L. Light, Dayton, President-Elect; Lawrence C. Meredith, Elyria, Past President; Paul N. Ivins, Hamilton; George J. Schroer, Sidney; Frederick T. Merchant, Marion; Robert N. Smith, Toledo; P. John Robeck, Cleveland; Edwin R. Westbrook, Warren; Sanford Press, Steubenville; James A. Quinn, Jr., Newark; Oscar W. Clark, Gallipolis; Richard L. Fulton, Columbus; William R. Schultz, Wooster, District Councilors; Mr. Wayne E. Stichter, Toledo, OSMA legal counsel; Mr. David B. Weihaupt, Chicago, AMA Field Representative; Mr. James Imboden, Columbus, Ohio Medical Political Action Committee; Messrs. Page, Edgar, Gillen, Traphagan, and Campbell of the OSMA Headquarters Office.

Minutes Approved

Minutes of meetings of The Council held March 18-19 and April 11, 1967 were approved.

Committee Appointments Ratified

By official action, The Council ratified the appointments to special committees for 1967-68, as presented by Dr. Howard. (See this issue of *The Ohio State Medical Journal*, beginning on page 991, for the personnel of these committees.)

Visual Care Program

A communication and a resolution from the Knox County Medical Society concerning a complete "visual care program for low income families in Knox, Holmes, and Coshocton Counties," sponsored by the Office of Economic Opportunity, and utilizing the services of optometrists, was referred to the Committee on Government Medical Care Programs.

AMA Disability Insurance

The Council discussed the American Medical Association disability insurance problem. It was the decision of The Council that Ohio's AMA delegation utilize resources offered by Dr. Edmond K. Yantes, i.e., the services of Mr. Frank Van Holte, Columbus, and that Mr. Jerry Campbell of the OSMA Staff work closely with the delegation on this matter.

Conference on Physician Shortage in Ohio

With regard to a communication dated May 9, 1967, from Dr. Benjamin W. Gilliotte, Zanesville, President of the Ohio Academy of General Practice, Council authorized the participation of the Ohio State Medical Association in the proposed "Conference on the Physician Shortage in Ohio," to be held July 30, 1967, in Columbus. The Council expressed willingness to provide additional consultants to the conference and offered the services of the chairman of the OSMA Rural Health Committee, Dr. Robert E. Reiheld, Orrville. It was suggested by The Council that the title for the theme of the meeting should be "Medical Manpower in Ohio."

Senate Bill 303

The Council voted to support, in principle, Senate Bill 303, subject to the clearance of the OSMA legal counsel, to provide for joint building projects, including schools for handicapped children, and for the joint exercise of powers of boards of education of the public schools.

1967 Annual Meeting

The Council expressed approval of the planning and operation of the 1967 Annual Meeting and commended Mr. Traphagan for his work in this regard.

Ohio Society of Medical Assistants

Under date of May 14, 1967, a resolution of the Ohio Society of Medical Assistants was presented to The Council. The Council acknowledged this expression with appreciation.

Dates for Future Meetings

Meeting dates established by The Council were: Wednesday, July 26; Friday, Saturday, and Sunday, September 15, 16, 17; Wednesday, October 18; Wednesday, December 6, 1967.

There being no further business, The Council adjourned until the next meeting on July 26, 1967.

Attest: HART F. PAGE
Executive Secretary

OAGP Scientific Assembly...

General Practitioners Will Meet in Columbus for Annual Scientific Program and Business Meeting

THE Ohio Academy of General Practice will hold its 17th Annual Scientific Assembly at the Sheraton-Columbus Motor Hotel, in downtown Columbus, on Tuesday, Wednesday, and Thursday, August 1, 2, and 3.

Registration will open at 12:00 NOON on August 1, with the first program feature at 1:30 P. M. Additional information may be obtained from the Academy headquarters, 4075 N. High Street in Columbus.

The program has been announced as follows:

Tuesday Afternoon, August 1

Abortion — Medical, Social, and Legal Aspects — Senator John Bermingham, Denver.

New Drugs in Arthritis — Vol K. Philips, M. D., Columbus.

Old But Useful Drugs — Ralph J. Lum, Jr., M. D., Puerto Rico.

Diabetes and Prediabetes — T. S. Danowski, M. D., Pittsburgh.

Tuesday Evening: Social Hour and Delegate Dinner.

Wednesday Morning, August 2

"Cornflakes" Conferences:

1. Future Trends in Private Practice of Medicine from the GP's Standpoint — Ralph J. Lum, Jr., M. D.

2. Revolution in Tetanus Prophylaxis — Wesley E. Furste, M. D.

3. Review of Research Findings and Application to the Cystic Fibrosis Victim — Gordon A. Young, M. D.

Some More Fundamentals of Chest Roentgenology — Benjamin Felson, M. D.

Diagnosis and Treatment of Cystic Fibrosis — Gordon A. Young, M. D., Columbus.

Is Geriatrics Pounding at Your Door? — C. Howard Ross, M. D., Ann Arbor.

Heart Attacks Need Not Happen — Robert S. Green, M. D., Cincinnati.

Wednesday Luncheon Period

"Sandwich" Seminars:

1. Practice of Good Family Medicine — Robert S. Green, M. D.

2. Granny's Herbs and the Witch Doctor — C. Howard Ross, M. D.

3. Hepatic Coma — Richard L. Wechsler, M. D.

4. Food for Thought — Philip Thorek, M. D.

5. The Anti-Atherogenic Diet — Carlos P. Lamar, M. D.

Wednesday Afternoon

Diagnosis and Therapy of Vascular Disease of the GI Tract — Richard L. Wechsler, M. D., Pittsburgh.

The Acute Abdomen — Philip Thorek, M. D., Chicago.

Epilepsy and the Law — Howard D. Fabing, M. D., Cincinnati.

Technique and Results in Chemical Endarterectomy — Carlos P. Lamar, M. D., Miami.

Wednesday Evening: Marion Laboratory Party and Officers' Reception

Thursday Morning, August 3

Exhibitors' Breakfast

Practical Application of Pulmonary Function Tests — Benjamin Schuster, M. D., Dayton.

Public Health Aspects of Pesticide Use — Frank L. Lyman, M. D., Ardsley, N. Y.

Legal Implications of Emergency Care — Neil L. Chayet, LL. B., Boston.

Long Term Effects of Estrogen-Progestin Treatment — Alvin F. Goldfarb, M. D., Philadelphia.

The Veterans Administration recently announced that it has 30 openings for career resident physicians in physical medicine and rehabilitation. The openings are in 25 VA hospitals, which are affiliated with medical schools. Interested persons may contact the Chief Medical Director (117), Veterans Administration Central Office, Washington, D. C. 20420.

Presenting Officers and Councilors Elected at the Annual Meeting

THE HOUSE OF DELEGATES of the Ohio State Medical Association named a President-Elect at the 1967 Annual Meeting in Columbus, May 15-19, and convened in unique session for installation of the Incoming President and other ceremonial functions. The election included naming of a new Treasurer and two new Councilors, election of a Councilor previously appointed to fill an unexpired term, and re-election of certain other members of The Council. Following are brief biographical sketches of these new officers and Councilors with additional information on other members of The Council.

Dr. Theodore L. Light, of Dayton, was named President-Elect of the Association, and will assume the Presidency at the 1968 Annual Meeting in Cincinnati next May. A practicing physician in Dayton, specializing in internal medicine, Dr. Light has served on The Council since 1963 as Councilor of the Second District.

Dr. Light is a native of Dayton. His undergraduate training was at the University of Cincinnati where he remained to receive his medical degree from the University of Cincinnati College of Medicine in 1937. Internship and residency training followed at Miami Valley Hospital.



Dr. Light

During World War II, Dr. Light became a flight surgeon with the 319th Bomber Group, and served in the Mediterranean Theater. Active service was from 1942 to 1945. His membership in the Montgomery County Medical Society, and in the State Association, dates back to 1938, and he was a member of the Council of the local Society from 1947 to 1957; was secretary, 1947; vice-president, 1948 and 1951; and president, 1955. In 1956 he received the Outstanding Service Award of the Society. From 1950 to 1963 he was a delegate of the local Society to the OSMA House of Delegates.

Dr. Light was elected to The Council of the Ohio State Medical Association in 1963 as Councilor of the Second District, and was re-elected to that office in 1965. In 1959 he was first elected an Alternate Delegate to the American Medical Association, and 1964 was elected a full Delegate.

In addition to his memberships in the local and state associations as well as the AMA, he is a member of the Aero Space Medical Association, Civil Aviation Medical Association, and Industrial Medical Association. Other affiliations include memberships on the Dayton Area Heart Association Executive Board, Hospital Planning Council of the Greater Miami Valley Medical Advisory Committee, Kettering Memorial Hospital Foundation, in which he is cochairman of the Medical Advisory Committee, and chairman of the Building Plans Committee, and Montgomery County Society for Cancer Control Executive Board. Since February of 1966 he has been on the Governor's Advisory Committee for Title XIX of the Ohio Department of Public Welfare.

Among community activities, he has been a promoter of the Boy Scouts movement since 1940, and in 1953 was presented the Silver Beaver award of that organization. He has also been on the Executive Board of the Camp Fire Girls; was president of the board, and received that organization's "Gulick Award."

He also has been active in the local Chamber of Commerce; is a member and former vice-president of the Dayton Board of Education; is a member and former president of the Dayton

Kiwanis Club; and he is a vestryman and senior warden in the Episcopal Church.

Dr. and Mrs. Light have four children—Richard who is a doctor of medicine, Linda and Eleanor, registered nurses, and Mary Ellen, a student.

Incoming President

Dr. Robert E. Howard, Cincinnati, was installed as President of Association at a special inaugural session of the House of Delegates on May 16, and assumed the office at the close of the 1967 Annual Meeting in Columbus. He was



Dr. Howard

named President-Elect at the 1966 Annual Meeting in Cleveland, after serving four years on The Council as Councilor of the First District.

A practicing physician for some 36 years in Cincinnati, Dr. Howard specializes in otolaryngology. As President-Elect during the past year, he has served as ex-officio member of the Association's numerous committees, has traveled extensively in behalf of the medical profession, visited neighboring states, attended AMA meetings, and made special trips to Washington and Chicago.

Dr. Howard was born in Dayton and took part of his undergraduate training at Ohio Wesleyan University. Continuing his studies at the University of Cincinnati, he earned the A. B., B. S., and B. M. degrees, before he was awarded the M. D. degree from the College of Medicine in 1928. Postgraduate training included study tours at the University of Pennsylvania and the University of Vienna, as well as at Cincinnati General Hospital and the University of Cincinnati College of Medicine. Long a member of the faculty at the University of Cincinnati College of Medicine, he is now associate professor of otolaryngology, and lectures

in otology and clinical anatomy of the head and neck. He is certified by the American Board of Otolaryngology and is on the staffs of nine Cincinnati hospitals.

Dr. Howard was first elected as Councilor of the First District in 1962 and was re-elected in 1964. He is a Past President of the Academy of Medicine of Cincinnati, and further served the Academy as Secretary-Treasurer and as member of the Board of Trustees. He also has been President of the Cincinnati Medical-Dental-Hospital Bureau, and the Cincinnati Speech and Hearing Center.

Before being named to The Council, Dr. Howard served in the House of Delegates, representing Hamilton County. Among additional services on the state level, he was chairman of the Auditing and Appropriations Committee of the Association and chairman of the Medical Advisory Committee to the Ohio State Society of Medical Assistants. The International Alpha Kappa Kappa Medical Fraternity recently named him as First Grand Vice-President.

Among other professional affiliations he is a member of the American Medical Association and the American Academy of Ophthalmology and Otolaryngology.

He has three sons and a daughter; and his wife Betty is a graduate nurse from Bethesda School of Nursing in Cincinnati.

Treasurer

The House of Delegates elected Dr. James L. Henry, of Columbus, as Treasurer for a three-year term, to succeed Dr. Philip B. Hardyman, of Columbus, who had served the maximum of two three-year terms in that office.



Dr. Henry

Dr. Henry is a general practitioner in Grove City and is Past President of the Academy of Medicine of Columbus and Franklin County. He was named President-Elect of the Academy in 1958, after completing a term as Treasurer of the local society. In numerous other ways he has been active in Academy affairs. He served as chairman of the Utilization Review Committee, as chairman of the Medical Service Committee, and as Academy representative to the Press Code Committee. He has also served as chairman of the

Family Practice Committee and as a member of the Professional Relations Committee.

His hospital activities also have been varied. At Mt. Carmel Hospital, Columbus, he was chairman of the Department of General Practice, editor of the Mt. Carmel news bulletin, chairman of the Disaster Committee, and secretary of the Medical Advisory Board at Mt. Carmel. On the state level, he has served on the Ohio State Medical Association's Committee on Care of the Aging.

Dr. Henry is a graduate of Ohio State University College of Medicine, class of 1944, served his internship at the former St. Francis Hospital in Columbus, and from 1945 to 1947 served in the Army Medical Corps.

In 1966, Dr. Henry had the distinction of having a humorous novel published under his authorship. With the setting of a day at the races, he brought together as characters a number of typical race track buffs and followed their antics through nine races. The resulting humorous novel bears the title *Charlie Horse*.

Dr. Henry is married and has a daughter in college and a son in high school.

Second District Councilor

The House of Delegates elected Dr. George J. Schroer, general practitioner of Sidney, as Councilor of the Second District, to succeed Dr. Light.

Dr. Schroer previously served one year on The Council. In 1962 he was named to fill a year of the unexpired term of the late Dr. Ray M. Turner of Springfield.

Currently president of the Shelby County Medical Society, he is a member of the board of directors of Ottawa Valley Tuberculosis Hospital, Lima, and a member of the courtesy staff of Dettmer Hospital, Troy; also a member of the staff, and former chief of staff, Wilson Memorial Hospital, Sidney.



Dr. Schroer

Dr. Schroer lived most of his life in west-central Ohio; was born at Coldwater, in neighboring Mercer County. He received his bachelor's degree from Ohio State University in 1943, and his M. D. from the OSU College of Medicine in 1946. Internship was at Miami Valley Hospital, Dayton. From 1947 to 1949 he was in

military service, stationed at the Aero-Medical Laboratory and Base Hospital, Wright Patterson Air Force Base.

Until recently, Dr. Schroer was a solo practitioner. In 1965 he, Dr. Richard Breece, and Dr. Thomas Hunter formed a three-way partnership for practice in Sidney.

Dr. Schroer is married to the former Mildred Hoying, a registered nurse graduate of Good Samaritan Hospital. They have three sons and a daughter, two in college and two in high school.

Eighth District Councilor

The House of Delegates elected Dr. James A. Quinn, Jr., of Newark, as Councilor of the Eighth District, to succeed Dr. Robert C. Beardley, of Zanesville, who has served the maximum of three terms in that office.

Dr. Quinn is a specialist in pathology and is director of laboratories for the Licking County Hospital Association in Newark, a post he has held since 1959. An active participant in affairs



Dr. Quinn

of the Licking County Medical Society, he served as secretary-treasurer from 1960 to 1965. Currently he is president of the Central Ohio Society of Pathologists.

A native of Cincinnati, Dr. Quinn's undergraduate studies at the University of Cincinnati were interrupted by military service during World War II. From 1943 to 1946 he was a pilot with the U. S. Navy, and for several years after the war remained in the Naval Reserve, first as a pilot and later as a medical officer.

Returning to the University of Cincinnati after the war, he received his medical degree from the College of Medicine in 1951, and remained at Christ Hospital, in Cincinnati, for his internship. Residency training in pathology was begun at Christ Hospital, and continued in association with the Youngstown Hospital Association. From 1956 to 1958 he was associate pathologist and director of cancer research for the Youngstown Hospital Association. Before his present affiliation, he was associate pathologist for the Bon Secours Hospital, Grosse Pointe, Michigan.

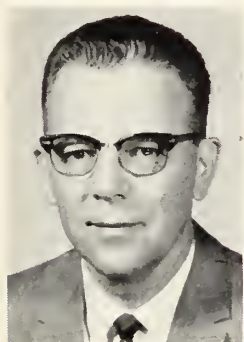
Dr. Quinn is a diplomate of the American Board of Pathology, certified in both anatomic

and clinical pathology, and is qualified also in the field of radioisotopes. He is a member of the American Medical Association, the College of American Pathologists, and the American Society of Clinical Pathologists.

Dr. Quinn is married to the former Minta Akers, of Charleston, W. Va., and has two sons, James, 14, and Daniel, age 11.

Ninth District Councilor

The House of Delegates elected Dr. Oscar W. Clarke, of Gallipolis, to fill the remaining year of an unexpired term. He was appointed to that position by The Council at its September 10-11, 1966 meeting, when Dr. George N. Spears, of Ironton, resigned for personal reasons.



Dr. Clarke

Dr. Clarke is a practicing physician in the Gallipolis area, specializing in internal medicine, and is chief of the Department of Internal Medicine at the Gallipolis Clinic and the Medical Center Hospital

He is a graduate of the Medical College of Virginia, a diplomate of the American Board of Internal Medicine, a Fellow of the American College of Physicians, and a charter member and former trustee of the Ohio Society of Internal Medicine.

Dr. Clarke is a past president of the Gallia County Medical Society. On the state level he has served on the OSMA Committee on Hospital Relations and the Committee on Workmen's Compensation.

In Heart Association activities he is a member of the council of the Gallia County Heart Association, a trustee of the Central Ohio Heart Association, and a member of the Education Committee of the Ohio Heart Association.

He is president of the Gallipolis City Board of Health, a past president of the Gallipolis Rotary Club, past president of the Tri-County Community Concert Association, member of the executive committee of the Gallia County Community Industrial Council, and a trustee of the Medical Memorial Foundation.

Mrs. Clarke, the former Susan Frances King of Kalispell, Montana, is a member-at-large of the Woman's Auxiliary to the OSMA. The Clarks have three daughters, Susan, Elisabeth,

and Jennifer. Family affiliation is with the First United Presbyterian Church of Gallipolis.

Other Members of The Council

Dr. Lawrence C. Meredith, Elyria, as Immediate Past President, will serve an additional year on The Council.

Dr. Robert N. Smith, Toledo, was re-elected Councilor of the Fourth District. He was first elected to that office in 1963, and re-elected in 1965.

Dr. Edwin R. Westbrook, Warren, was re-elected Councilor of the Sixth District. He was first elected to that office in 1963 and re-elected in 1965.

Dr. Richard L. Fulton, Columbus, was re-elected Councilor of the Tenth District. He was first elected to that office in 1963, and re-elected in 1965.

Councilors in the midst of two-year terms are Dr. Paul N. Ivins, Hamilton, First District; Dr. Frederick T. Merchant, Marion, Third District; Dr. P. John Robeck, Cleveland, Fifth District; Dr. Sanford Press, Steubenville, Seventh District; and Dr. William R. Schultz, Wooster, Eleventh District.

Continuing Education Program, Joint Effort in Cincinnati

"Conmed" — continuing education for physicians — is being introduced in Cincinnati this summer.

Through co-operative efforts of the Academy of Medicine of Cincinnati, University of Cincinnati College of Medicine, and four affiliated community hospitals, the new program was organized. Participating hospitals are Bethesda, Christ, Good Samaritan, and Jewish.

Dr. Elmer R. Maurer, Academy president, and Dr. Clifford G. Grulee Jr., dean of UC's medical college, announced details of the new program. Dr. Harold Schiro is chairman of the Academy's Conmed Committee.

Emphasizing the profound interest of the Academy of Medicine in graduate medical education over the past years, Dr. Maurer noted "the entire medical community and all of those whom they might attend will profit from this combined community endeavor."

"It is sincerely hoped that other community hospitals may in time join the program," Dr. Maurer said.

The program sponsored by Conmed includes side study and ward-round teaching, conferences, lectures, and demonstrations and is available to interns, residents, practicing physicians, and others.

Sessions are presented in each participating hospital as well as at the UC Medical Center and the Academy.

Proceedings of the House of Delegates

1967 Annual Meeting

MINUTES OF FIRST SESSION

THE first session of the House of Delegates of the Ohio State Medical Association was held at the Sheraton-Columbus Hotel, Columbus, Monday evening, May 15, 1967.

Dr. Tom F. Lewis, President of the Columbus Academy of Medicine, welcomed the delegates to Columbus and introduced President Lawrence C. Meredith, Elyria.

Report on Delegates Present

The Credentials Committee reported 161 delegates seated and eligible to vote. A number of alternate delegates, officers, and executive secretaries of county medical societies were in attendance.

1966 Minutes Approved

The minutes of the 1966 sessions of the House of Delegates, as published in the July, 1966, issue of *The Ohio State Medical Journal*, were approved by official action.

AMA-ERF Checks Presented

The following representatives of Ohio's medical schools were presented checks from the American Medical Association Medical Education and Research Foundation by President Meredith: Dr. Frederick T. Suppes, representing the Western Reserve University School of Medicine; Dr. Clifford G. Grulee, Jr., Dean, University of Cincinnati College of Medicine; Dr. Richard L. Meiling, Dean, Ohio State University College of Medicine.

AMA Certificate of Appreciation

A certificate of appreciation to Dr. Edmond K. Yantes, Wilmington, for five years of service on the AMA Council on Rural Health, was presented by Dr. Meredith.

Introduction of Honored Guests

Dr. Meredith introduced the following honored guests:

Dr. Eugene S. Rifner, Van Buren, Indiana, president of the Indiana State Medical Association; Dr. Richard E. Flood, Weirton, West Virginia, president of the West Virginia State Medical Association; Dr. James S. Klumpp, Huntington, West Virginia, past

president of the West Virginia State Medical Association.

Reference Committees Appointed

The following House of Delegates Reference Committees were appointed by the President:

Credentials of Delegates — Ben V. Myers, Lorain County, Chairman; Roger C. Henderson, Greene County; Chester R. Jablonoski, Cuyahoga County; G. E. DeCicco, Mahoning County; Clarence L. Johnson, Hardin County.

President's Address — Emil J. Meckstroth, Erie County, Chairman; Chester J. Brian, Preble County; Roger Peatee, Wood County; Daniel V. Jones, Hamilton County.

Resolutions Committee No. 1 — James C. McLarnan, Knox County, Chairman; Carl A. Minning, Clermont County; Jerry L. Hammon, Miami County; Dwight L. Becker, Allen County; George N. Bates, Lucas County; Elden C. Weckesser, Cuyahoga County; Daniel W. Mathias, Summit County; Robert E. Rinderknecht, Tuscarawas County; Jack L. Kraker, Fairfield County; Richard E. Bullock, Vinton County; William R. Graham, Huron County.

Resolutions Committee No. 2 — Frederick P. Osgood, Lucas County, Chairman; Charles A. Sebastian, Hamilton County; James G. Tye, Montgomery County; Donald R. Brumley, Hancock County; Robert A. Irvin, Lake County; Maurice F. Lieber, Stark County; Robert R. Johnson, Coshocton County; Kenneth E. Bennett, Washington County; Albert M. Shrader, Pike County; Jasper M. Hedges, Pickaway County; Albert Burney Huff, Wayne County.

Resolutions Committee No. 3 — James T. Stephens, Lorain County, Chairman; Robert P. Johnson, Butler County; Maurice M. Kane, Darke County; Walter A. Daniel, Seneca County; William J. Neal, Fulton County; William F. Boukalik, Cuyahoga County; Leonard P. Caccamo, Mahoning County; Glenn C. Dowell, Carroll County; Carl E. Spragg, Muskingum County; Joseph T. Gohmann, Scioto County; Charles W. Pavey, Franklin County.

Tellers and Judges of Election — Ernest H. Winterhoff, Clark County, Chairman; William Dorner, Jr., Summit County; Harry K. Hines, Hamilton County; Edward F. Ockuly, Lucas County; Shepard A.

Burroughs, Ashtabula County; Clarence C. Fitzpatrick, Jackson County.

Nominating Committee Elected

The House of Delegates nominated and elected the following persons, one from each district, for the Committee on Nominations:

First District — Harry K. Hines, Hamilton County.

Second District — Jerry L. Hammon, Miami County.

Third District — Fred P. Berlin, Allen County.

Fourth District — Edwin C. Winzeler, Henry County.

Fifth District — James O. Barr, Cuyahoga County.

Sixth District — G. E. DeCicco, Mahoning County.

Seventh District — David M. Creamer, Belmont County.

Eighth District — J. H. Kennedy, Licking County.

Ninth District — Roger P. Daniels, Meigs County.

Tenth District — Robert E. Swank, Ross County.

Eleventh District — William R. Graham, Huron County.

Dr. Meredith announced that under the system of rotation approved by the House of Delegates in 1963, the chairman of the committee this year would be the nominee from the Fifth District, Dr. James O. Barr, Cuyahoga County.

Introduction of Resolutions

Dr. Meredith then called for the introduction of resolutions. He ruled that resolutions which had been presented within the 60-day time limit and had been distributed to the delegates in advance of the meeting should be read by title only for referral. Twenty-six resolutions were ready by title only and referred to the resolutions committees.

New Resolutions Presented

Dr. Meredith then called for the presentation of new resolutions. The following resolutions by consent of two-thirds of the delegates present, were accepted for consideration by the House, and referred to the Resolutions Committees:

RESOLUTION NO. 28

Welfare Department's Failure to Meet Assumed Responsibilities

(By The Council, Ohio State Medical Association)

WHEREAS, The Council of the Ohio State Medical Association last year entered into a temporary agreement with the Ohio Department of Public Welfare whereby the Department agreed to reimburse physicians 60 per cent of their usual, customary, and reasonable fees for professional medical services to welfare recipients, and

WHEREAS, The Department, as a part of this agreement, pledged that it would request the Ohio General Assembly, during the current session, to appropriate sufficient funds to reimburse physicians their full usual, customary, and reasonable fees, and

WHEREAS, This Association, through Councilor District conferences, newsletters, special newsletters, and other means, devoted unusual time and effort in explaining

the agreement to members of the Association and soliciting their support and acceptance of said agreement, and WHEREAS, Despite repeated requests to the Department from this Association for definite assurance that the Department had so requested of the General Assembly funds necessary to provide usual, customary, and reasonable fee payment, and

WHEREAS, The Department, less than four hours before the House Finance Committee's hearing May 10, 1967, on the proposed welfare budget, informed the Association that (1) the necessary funds were not in the budget being considered by said committee and (2) the Department would, therefore, not reimburse physicians more than 60 per cent of their fees for professional services, NOW, THEREFORE, BE IT

RESOLVED, That this House of Delegates decrees that said agreement is herewith terminated, AND BE IT FURTHER

RESOLVED, That members of this Association are strongly urged to continue to bill directly, as in accord with established policies of this House of Delegates and The Council, all patients, regardless of what agreement a patient may have with a third party, AND BE IT FURTHER

RESOLVED, That members of this Association inform all their patients, regardless of any government medical care program, that they expect their patients to provide full reimbursement for their professional services, AND BE IT FURTHER

RESOLVED, That this action is in complete accord with that statement in the U. S. Department of Health, Education, and Welfare "Report to the President on Medical Care Prices," February, 1967, which reads: "Charity medicine is being abandoned in favor of new public programs which give needy people the resources to purchase medical care from private physicians and hospitals on the same basis as more affluent citizens."

RESOLUTION NO. 29

Medical Care Fees for Military Dependents

(By Summit County Medical Society)

WHEREAS, The House of Delegates of the AMA in June, 1957 as a result of a resolution from OSMA, expressed its disbelief in fixed fee schedules for Military Dependents Medical Care Act (Public Law 569) and urged the Board of Trustees of the AMA to continue its effort toward modification of the Military Dependents Medical Care Program's regulations and directions so that the program can be operated as an indemnity type of program where desired by individual states, and

WHEREAS, The House of Delegates of the AMA reaffirmed this policy in December, 1957 in response to a resolution from Rhode Island, and again in June, 1958 in response to resolutions from Tennessee, Georgia, and Arkansas, and

WHEREAS, The House of Delegates of the AMA in June, 1966 in response to a resolution from OSMA urged the Board of Trustees of the AMA to take all necessary actions to effect changes in the regulations and directives of the Military Dependents Medical Care Act to provide that patients eligible for benefit under this act be afforded the same option of direct reimbursement for physicians' fees as in Part B Medicare (Public Law 89-97), and

WHEREAS, To date no progress has been made in this regard and as a result the physicians of Ohio and the nation have imposed upon them by the Department of Defense and the Mutual of Omaha Insurance Company a fixed-fee, payment-in-full program determined arbitrarily by these agencies, THEREFORE BE IT

RESOLVED, That the House of Delegates of the AMA instruct the Board of Trustees of the AMA to renew its efforts to bring about a change in the regulations and directives relative to Public Law 569—84th Congress (Military Dependents Medical Care Act) which will permit the program to operate on a like manner as Public Law 89-97 Title XVIII—Part B Medicare, AND BE IT FURTHER

RESOLVED, That the Board of Trustees be instructed to report semiannually to the House of Delegates of the

AMA its efforts and progress in this regard until its purpose is accomplished, AND BE IT FURTHER
RESOLVED, That the OSMa Delegates to the AMA present this resolution to the House of Delegates of the AMA.

RESOLUTION NO. 30

Nursing Education

(By The Council, Ohio State Medical Association)

WHEREAS, The National League for Nursing estimates there will be a shortage of 350,000 registered nurses by 1970, and

WHEREAS, The American Nurses Association's 'Position Paper' on nursing education casts unverified doubts on the quality of nursing education in hospital-based diploma nursing programs which produce over 80 per cent of the nation's bedside nurses, and

WHEREAS, The ANA 'Position Paper' infers that diploma schools should be closed, and

WHEREAS, The closing of hospital-based diploma programs would compound the acute shortage of bedside nurses, NOW, THEREFORE, BE IT

RESOLVED, That efforts be made to identify and utilize financial resources in support of these schools, and BE IT FURTHER

RESOLVED, That this Association oppose the ANA 'Position Paper' on nursing education as tending to decrease the enrollment in diploma programs by casting doubt on their quality and efficacy, AND BE IT FURTHER

RESOLVED, That the Ohio Delegation to the American Medical Association is hereby instructed to present and support a similar resolution at the 1967 Annual Meeting of the AMA.

Following announcements about meetings of the Reference Committees and subsequent sessions of the House of Delegates, the House recessed until Tuesday afternoon, May 16.

MINUTES OF INAUGURAL SESSION

The inaugural session (second session) of the House of Delegates of the Ohio State Medical Association was opened with the invocation by the Reverend Frederick T. Schumacher, The First Church in Oberlin.

Music was provided by the Montgomery County Medical Society Glee Club under the leadership of Dr. W. J. Lewis, Dayton.

Introduction of Guests

Ohio State Medical Association past presidents and past members of The Council were introduced, as well as county medical society presidents. Representatives of other state medical associations and representatives of allied organizations were presented. Members of The Council were introduced as was Dr. Samuel Saslaw, Columbus, chairman of the Committee on Scientific Work.

Plaques Presented

Plaques were presented to the following past members of The Council: Dr. Henry A. Crawford, Cleveland; Dr. Robert C. Beardsley, Zanesville; Dr. George Newton Spears, Ironton; Dr. Benjamin C. Diefenbach, Columbus; Dr. Philip B. Hardyman, Columbus.

Report of Woman's Auxiliary President

At this time Mrs. James N. Wychgel, Cleveland, President of the Woman's Auxiliary to the Ohio

State Medical Association, was presented and gave a report on Auxiliary activities to the House of Delegates. (See pages 973-974 for the text of Mrs. Wychgel's address.)

AMA Certificates of Humanitarian Service

Certificates of humanitarian service were awarded to nine Ohio physicians for their service in South Vietnam. Present to receive their certificates were the following Ohio physicians: Dr. Robert E. Cooke, Harrison; Dr. James Q. Dorgan, Jr., Columbus; Dr. Mark T. Hoekenga, Cincinnati; Dr. Anthony C. Nas-sif, Cleveland; Dr. James B. Patterson, Lorain; Dr. Robert E. Sooy, Mt. Vernon. Not present to receive the certificates were the following physicians: Dr. Joseph H. Gaudreault, Hickley; Dr. Rainer S. Pakusch, Dearborn, Michigan (formerly Maumee, Ohio); Dr. Jerry C. Rosenberg, Toledo.

President's Address

Dr. Lawrence C. Meredith, President of the Ohio State Medical Association, then delivered his presidential address. (See pages 962-964 for the text of his address.)

Oath of Office

Dr. Henry A. Crawford, Cleveland, past president, administered the oath of office to Dr. Robert E. Howard, Cincinnati, President-Elect, and the symbolic Crile gavel was passed to Dr. Howard.

Inaugural Address of Incoming President

Dr. Howard then delivered his inaugural address, the text of which appears on pages 966-967.

The House then recessed until 9 A. M., Friday, May 19.

MINUTES OF FINAL SESSION

The final business session of the House of Delegates of the Ohio State Medical Association at the 1967 Annual Meeting was held on Friday morning, May 19, at the Sheraton-Columbus Hotel.

The following guests were introduced by President Meredith: Dr. George F. Brockman, Greenville, Kentucky, president-elect of the Kentucky Medical Association; Dr. Richard E. Flood, Weirton, West Virginia, president of the West Virginia State Medical Association; Dr. K. M. Kressenberg, Pulaski, Tennessee, president of the Tennessee Medical Association.

Report of Credentials Committee

Dr. Ben V. Myers, Lorain County, chairman of the Committee on Credentials of Delegates, reported 155 delegates were seated and eligible to vote. Also present were alternate delegates, officers, and other guests.

Committee on President's Address

Dr. Meredith called for a report of the Reference Committee on the President's Address, which was presented by Dr. Emil J. Meckstroth, Erie County, chairman of the committee. It read as follows:

"The members of this Reference Committee on

President's Address feel that we are confronted with a real challenge. The challenge is not whether this committee is willing, but the challenge is, are we able?

"The committee did refresh its knowledge as to the duties of the President and President-Elect as set forth in our Constitution and Bylaws. As you all know, the President is the principal administrative officer of the Association, appoints all committees, is chairman of The Council and is an ex-officio member of all committees.

"Presidents and Presidents-Elect are not picked out of the sky. They have had years and years of experience in medical association work on the component county level, district, and state level. The mill wheel keeps going round and round; then all of a sudden the courtship is changed into a marriage when the physician is elected President-Elect, but the treadmill does not stop. This marriage is successful because there is no act of domination or failure to help others.

"Repeatedly in the President's Address are accumulations of wisdom. These expressions of wisdom really signify a profound depth of experience inherent in the President. This is good because it acts as a stimulus for all doctors and makes them able to communicate ideas.

"There is also a careful appraisal and a keen reminder of the drift toward insidious bureaucratic guidance of American thought and action, however benign its beginnings. In the field of medical care, the President called this the propulsion and the threat of control of medicine by creative federalism.

"The President referred to the many positive and progressive actions that have been taken at the county level and state committee level, e.g., the Committee on Maternal Health, the newly created Committee on Government Medical Care Programs and the help it has been to The Council. He also reviewed the actions of The Council, including the visitation of members of The Council and members of the Committee on Legislation with Ohio Congressmen in Washington, D. C. He urged us to look ahead and that our commitment demands contribution of our time, experience, and ability beyond mere patient care.

"Dr. Robert Howard, in his inaugural address, reminded us that in this era we cannot allow the fact that we are physicians stand in our way of becoming complete citizens. We must become more active politically. He pledges his efforts to keep the Ohio State Medical Association at the top, with the combined help of the officers, councilors, delegates, committeemen, and the physicians representing the grass roots.

"We wish to emphasize that Dr. Howard stated that for government to expect physicians to subsidize the medical part of various welfare programs by providing professional services at below the usual and customary fees is not acceptable.

"Mr. President, I move the adoption of this report.

"I wish to thank the members of my Committee for their careful study and evaluation of the outstanding addresses by the President and President-Elect of this Association. They are: Daniel V. Jones, Hamilton County; Chester J. Brian, Preble County; Roger A. Peatee, Wood County; Emil J. Meckstroth, Erie County, Chairman."

On motion made and seconded, the House of Delegates by official action approved the report of the Committee on the President's Address.

Reference to Original Text of Resolutions

The original texts of the resolutions considered at the 1967 Annual Meeting are printed on pages 668 to 676 of the May, 1967, issue of *The Ohio State Medical Journal*.

Report of Resolutions Committee No. 1

Dr. James C. McLarnan, Knox County, reported for Resolutions Committee No. 1, of which he was chairman. The report read as follows:

"Resolutions Committee No. 1 considered ten resolutions. Discussion was lively and enlightening. All who wished to testify were heard. The Committee gave thoughtful consideration to all testimony brought before it.

RESOLUTION NO. 3

AMA Council on Medical Education
(By the Mahoning County Medical Society)

"The Committee was in full accord with the intent of the resolution but felt that it could be clarified through amendments and submits the following amended resolution:

AMENDED RESOLUTION NO. 3 AMA Council on Medical Education

WHEREAS, Residency training programs are conducted by the staff members of the individual hospitals concerned, and

WHEREAS, All are interested in maintaining residency training programs at the highest possible level, whether in university or nonuniversity affiliated hospitals, and

WHEREAS, A nonuniversity affiliated hospital can provide a clinical program as successfully as a university hospital, and

WHEREAS, The composition of the Council on Medical Education of the American Medical Association comprises a membership consisting heavily of medical school faculty or former faculty providing thus for a situation which can possibly discriminate against nonuniversity affiliated hospitals, NOW, THEREFORE, BE IT

RESOLVED, That the House of Delegates of the Ohio State Medical Association, through its delegates to the American Medical Association, recommend to the American Medical Association that, as soon as possible, a change in composition of the American Medical Association Council on Medical Education be instituted to assure more equal representation on the Council by physicians practicing in nonuniversity affiliated hospitals in order to emphasize the teaching of clinical medicine.

"The Committee recommends the adoption of Amended Resolution No. 3 and, Mr. President, I so move."

By official action, the recommendation of the

committee, namely, that Amended Resolution No. 3 be adopted, was approved.

RESOLUTION NO. 6

Payment of Dues

(By the Academy of Medicine of Cincinnati)

"The discussion of this resolution brought forth no indication of a desire to change the amount of the dues now being billed but dealt entirely with the method of collection of dues and the fiscal problems pertaining thereto.

"The Committee, without changing the intent of the resolution, therefore submits Amended Resolution No. 6:

AMENDED RESOLUTION NO. 6

Payment of Dues

WHEREAS, A number of County Medical Societies in the larger metropolitan areas are experiencing budgetary problems which include expenses for the collection of dues of the Ohio State Medical Association and the American Medical Association, NOW, THEREFORE, BE IT

RESOLVED, That The Council of the Ohio State Medical Association be directed to study the problem of dues collection in its entirety and make appropriate recommendations, AND BE IT FURTHER

RESOLVED, That the Council be instructed to notify all County Medical Societies of a hearing or hearings that are to be scheduled before a final policy is adopted in reference to the collection of dues.

"The Committee recommends the adoption of Amended Resolution No. 6 and, Mr. President, I so move."

By official action, the recommendation of the committee, namely, that Amended Resolution No. 6 be adopted, was approved.

RESOLUTION NO. 10

Areawide Health Care Planning

(By the Summit County Medical Society)

"There was a lively discussion of this resolution. The testimony developed the point that emphasis in Federal programs has now been changed from Areawide Health Facility Planning to Areawide Health Care Planning, and that these planning boards now have the force of law behind them.

"The Committee felt the resolution could be strengthened by amendment. Your Committee, therefore, submits the following:

AMENDED RESOLUTION NO. 10

Areawide Health Care Planning

WHEREAS, The Congress saw fit to expand the program of Areawide Health Facility Planning into Areawide Health Care Planning with enabling legislation effective in Ohio, and

WHEREAS, Members of the medical profession are most knowledgeable concerning health care needs, and

WHEREAS, The medical profession has been effectively excluded in several communities from meaningful participation in either program, and

WHEREAS, The structure of these areawide health care corporations places in their boards of trustees broad, centralized authority over all health disciplines, the health departments, hospitals, extended care facilities, ancillary personnel and suppliers, NOW, THEREFORE, BE IT

RESOLVED, That the House of Delegates of the Ohio State Medical Association reaffirms its previous position

encouraging active physician participation, through County Medical Societies, on areawide health care planning boards, with full voting rights, and BE IT FURTHER

RESOLVED, That The Council of the Ohio State Medical Association inform each of its members, and the appropriate State and Federal agencies, of the dangers to the public health inherent in the omission of equal physician participation in these programs.

"Mr. President, I move the adoption of Amended Resolution No. 10.

By official action, the recommendation of the committee, namely, that Amended Resolution No. 10 be adopted, was approved.

RESOLUTION NO. 13

Physicians on Hospital Governing Boards

(By the Stark County Medical Society)

"The Committee heard no opposition to the proposed resolution but, by using its editorial discretion, made amendments to the resolution and submits for your consideration:

AMENDED RESOLUTION NO. 13

Physicians on Hospital Governing Boards

WHEREAS, Physicians are generally sparsely represented on hospital governing boards, and

WHEREAS, Such lack of representation has led to, and can lead to, unnecessary misunderstandings between medical staffs and hospital governing boards, and

WHEREAS, Most physicians are acutely aware of hospital problems, in many cases more so than nonphysician members of hospital governing boards, and

WHEREAS, Many parochial institutions are modernizing to encourage representation of the laity on their governing boards, and

WHEREAS, The AMA has already approved the principle of having physician members on hospital governing boards, NOW, THEREFORE, BE IT

RESOLVED, That the Ohio State Medical Association recommends that not less than 25 per cent of the voting members of hospital governing boards be physicians approved by the voting members of the medical staff of said hospital, and

RESOLVED, That The Council of the Ohio State Medical Association investigate and take such action as may be appropriate to amend the laws of the State of Ohio to insure such physician representation on hospital governing boards, as is described in this resolution, and BE IT FURTHER

RESOLVED, That the delegates to the American Medical Association of the Ohio State Medical Association request the AMA, at the next session of its House of Delegates, take all possible steps to make 25 per cent physician representation on hospital governing boards a requirement for accreditation by the Joint Commission on Accreditation of Hospitals.

"The Committee recommends the adoption of Amended Resolution No. 13 and, Mr. President, I so move."

By official action, the recommendation of the committee, namely, that Amended Resolution No. 13 be adopted, was approved.

RESOLUTION NO. 15

Outside Affiliations of Members of Medical Staff

(By J. G. Tye, M.D., Delegate from Montgomery County)

"It was the feeling of the Committee that the spirit of this resolution was to encourage continuation of the open staff policy, which has long been a part of the

Ohio State Medical Association policy. This Committee wishes to reaffirm this policy. The Committee is in agreement with the spirit of the resolution but feels it would add no new principles to present policy.

"The Committee recommends that the membership continue to work in their own hospitals for these open staff privileges, but also recommends that this specific resolution be not adopted and, Mr. President, I so move."

By official action, the recommendation of the committee, namely, that Resolution No. 15 NOT be adopted, was approved.

The House of Delegates amended the report of the Resolutions Committee with regard to Resolution No. 15 by adding the following sentence between the first and second sentences of the first paragraph: "This committee wishes to reaffirm this policy."

RESOLUTION NO. 17

Reapportionment for Equitable Representation
(By Academy of Medicine of Cleveland)

"The Committee was impressed by the expression of the resolution that there is, in fact, an inequity in representation of the individual physician throughout the State in the House of Delegates of the Ohio State Medical Association.

It is the consensus of the Committee that a solution to this important problem is beyond the scope of the Resolutions Committee and, therefore, the Committee recommends that this resolution, as stated, be not adopted but that the entire matter of apportionment of delegates to the Ohio State Medical Association Annual Meeting be referred, by The Council, to an appropriate committee for intensive study and report to the House of Delegates at the next Annual Meeting. Mr. President, I so move."

By official action, the recommendation of the committee, namely, that Resolution No. 17 NOT be adopted, but the matter referred to The Council for study by an appropriate committee, was adopted. This included instructions for a report to the House of Delegates on the matter at the next Annual Meeting.

RESOLUTION NO. 19

Legality of Blue Cross Coverage of Professional Fee for Medical Services Performed in a Hospital
(By the Montgomery County Medical Society)

"It was the belief of the Committee, after lengthy discussion, that this resolution attempted to cover multiple problems. One problem concerns the efforts of hospital-based physicians to be compensated for their services under direct billing. The second problem was the legality of Blue Cross Plans paying physicians for services directly.

"It is the understanding of the Committee that, at the present time, standing committees of the Ohio State Medical Association are studying these problems as they relate to Blue Cross versus Blue Shield in the payment of physician's services. We wish to re-

affirm our faith in their efforts. Your Reference Committee feels that every effort should be expended by the members, hospital staff members and the staff of the Ohio State Medical Association to assist all physicians in their efforts to bill patients directly. The Committee also feels that the matter of negotiation of fee payments with insurance companies should be referred to an appropriate committee of the Ohio State Medical Association.

"In making these recommendations, the Committee feels that the present Resolution No. 19 would fulfill no useful purpose as presented and recommends that the resolution not be approved. Mr. President, I so move."

By official action, the recommendation of the committee, namely, that Resolution No. 19 NOT be approved, was adopted.

The report of the Reference Committee on Resolution No. 19 was amended by the insertion of the following sentence between sentences one and two of the second paragraph: "We wish to reaffirm our faith in their efforts."

RESOLUTION NO. 22

Possible Violation of Anti-Trust Laws by the Federal Government in Concert with Blue Cross-Blue Shield Organizations Throughout the Country
(By the Huron County Medical Society)

"This resolution provoked much less discussion than the length of the resolution might seem to warrant. The consensus of the Committee was that the spirit of the resolution is to appeal to commercial insurance companies to retain insurance coverage for citizens over the age of 65 and to reinstate those policies for such people as may have been canceled with the advent of Medicare. Although the Committee is in sympathy with the spirit of this resolution, it feels that such a resolution would have little effect on the insurance companies involved, recognizing that the insuring of this segment of the population is expensive.

"The Committee, therefore, recommends that Resolution No. 22 be not approved and, Mr. President, I so move."

By official action, the recommendation of the committee, namely, that Resolution No. 22 NOT be approved, was adopted.

RESOLUTION NO. 23

OSMA Executive Vice-President
(By the Huron County Medical Society)

"It was brought out early in the discussion that it was not the intent of the resolution to criticize or to show any lack of confidence in the present OSMA officers and staff but that it was an attempt to provide another mechanism for more smoothly coordinating and augmenting their efforts. It is the feeling of the Committee that this resolution is too indefinite and that the discussion did not show the need for such a change at this time.

The Committee does feel, however, that some study could be made in the future of the possibility of hiring part time professional consultants for specific situations as they arise.

"The Committee, therefore, recommends that Resolution No. 23 NOT be adopted and, Mr. President, I so move."

By official action, the recommendation of the committee, namely, that Resolution No. 23 NOT be adopted, was approved.

RESOLUTION NO. 28

State Administration's Failure to Meet Assumed Responsibilities

(By The Council of the Ohio State Medical Association)

The last resolution considered by the Committee was an emergency resolution submitted by The Council at the first meeting of the House of Delegates and referred to Reference Committee by unanimous vote of the House of Delegates. The Committee heartily concurs with the spirit of the resolution and submits the following amended resolution:

AMENDED RESOLUTION NO. 28

State Administration's Failure to Meet Assumed Responsibilities

WHEREAS, The U.S. Department of Health, Education, and Welfare, in its "Report to the President on Medical Care Prices," February, 1967, states that:

"Charity medicine is being abandoned in favor of new public programs which give needy people the resources to purchase medical care from private physicians and hospitals on the same basis as more affluent citizens," and

WHEREAS, The Council of the Ohio State Medical Association last year entered into a temporary agreement with the Ohio Department of Public Welfare whereby the Department agreed to reimburse physicians 60 per cent of their usual, customary, and reasonable fees for professional medical services to welfare recipients, and

WHEREAS, The Department, as a part of this agreement, pledged that it would request the Ohio General Assembly, during the current session, to appropriate sufficient funds to reimburse physicians their full usual, customary, and reasonable fees, and

WHEREAS, This Association, through Councilor District conferences, newsletters, special newsletters and other means, devoted unusual time and effort in explaining the agreement to members of the Association and soliciting their support and acceptance of said agreement, and

WHEREAS, Repeated requests were made to the Department from this Association for definite assurance that the Department had so requested the General Assembly funds necessary to provide usual, customary, and reasonable fee payment, and

WHEREAS, The Department, less than four hours before the House Finance Committee's hearing May 10, 1967, on the proposed welfare budget, informed the Association that (1) the necessary funds were not in the budget being considered by said committee and (2) the Department would, therefore, not reimburse physicians more than 60 per cent of their fees for professional services, NOW, THEREFORE, BE IT

RESOLVED, That this House of Delegates decrees that said agreement is herewith terminated, and BE IT FURTHER

RESOLVED, That members of this Association are strongly urged to continue to bill directly, as in accord with established policies of this House of Delegates and The Council, all patients, regardless of what agreement a patient may have with a third party, and BE IT FURTHER

RESOLVED, That this Association insists that, whenever a Government Agency contracts to pay for medical services, the full usual, customary, and reasonable fee be provided, and BE IT FURTHER

RESOLVED, That members of this Association inform all their patients, regardless of any government medical care program, that they expect their patients to provide full reimbursement for their professional services, if possible, and BE IT FURTHER

RESOLVED, That the House of Delegates of the Ohio State Medical Association does hereby reaffirm its dedication to the principle of providing the best medical care to all people regardless of their ability to pay.

"Mr. President, I move the adoption of Amended Resolution No. 28.

Resolution No. 28 was re-referred to Resolution Committee No. 1 for redrafting.

By official action, the following redrafted Amended Resolution No. 28 was presented to the House by the Reference Committee No. 1:

REDRAFTED AMENDED RESOLUTION NO. 28

WHEREAS, The U.S. Department of Health, Education, and Welfare, in its "Report to the President on Medical Care Prices," February, 1967, states that:

"Charity medicine is being abandoned in favor of new public programs which give needy people the resources to purchase medical care from private physicians and hospitals on the same basis as more affluent citizens," and

WHEREAS, The Council of the Ohio State Medical Association last year entered into a temporary agreement with the Ohio Department of Public Welfare whereby the Department agreed to reimburse physicians 60 per cent of their usual, customary, and reasonable fees for professional medical services to welfare recipients, and

WHEREAS, The Department, as a part of this agreement, pledged that it would request the Ohio General Assembly, during the current session, to appropriate sufficient funds to reimburse physicians their full usual, customary, and reasonable fees, and

WHEREAS, This Association, through Council District conferences, newsletters, special newsletters, and other means, devoted unusual time and effort in explaining the agreement to members of the Association and soliciting their support and acceptance of said agreement, and

WHEREAS, Repeated requests were made to the Department from this Association for definite assurance that the Department had so requested the General Assembly funds necessary to provide usual, customary, and reasonable fee payment, and

WHEREAS, The Department, less than four hours before the House Finance Committee's hearing May 10, 1967, on the proposed welfare budget, informed the Association that (1) the necessary funds were not in the budget being considered by said committee and (2) the Department would, therefore, not reimburse physicians more than 60 per cent of their fees for professional services, NOW, THEREFORE, BE IT

RESOLVED, That this House of Delegates decrees that said agreement is herewith terminated, and BE IT FURTHER

RESOLVED, That members of this Association are strongly urged to continue to bill directly, as in accord with established policies of this House of Delegates and The Council, all patients, regardless of what agreement a patient may have with a third party, AND BE IT FURTHER

RESOLVED, That, since the government has assumed the responsibility of providing full payment for certain segments of the population who can pay for their own health care while failing to provide an equal level of payment for needy welfare recipients unable to meet their own health care expenses, this Association insists



An engraved silver tray is presented to Dr. and Mrs. Lawrence C. Meredith by Past President Henry A. Crawford. The tray is a gift to the Outgoing President from the Association as a token of appreciation for services rendered during his term of office.



This is Resolutions Committee No. 1 hearing discussions on resolutions referred to it by the House of Delegates. Chairman James C. McLarnan, of Mt. Vernon, is at the rostrum.



This is a view of part of the House of Delegates as it met in the first of three sessions during the 1967 Annual Meeting in the Sheraton-Columbus Hotel.

that, whenever a Governmental Agency contracts to pay for medical services, the full usual, customary, and reasonable fee be provided, AND BE IT FURTHER

RESOLVED, that this resolution is in complete accord with that official statement made by the U. S. Department of Health, Education, and Welfare in the department's "Report to the President on Medical Care Prices," February, 1967, which reads

"Charity medicine is being abandoned in favor of new public programs which give needy people the resources to purchase medical care from private physicians and hospitals on the same basis as more affluent citizens,"

AND BE IT FURTHER

RESOLVED, that the House of Delegates of the Ohio State Medical Association does hereby reaffirm its dedication to the principle of providing the best medical care to all people, regardless of their ability to pay.

By official action, the Redrafted Amended Resolution No. 28 was adopted.

"Mr. President, I move the adoption of the Report of Resolutions Committee No. 1 as a whole.

"As Chairman, I wish to express my appreciation to the members of the Committee for their wisdom, their vision and their hard work. I also wish to acknowledge the helpful services of the Legal Counsel of the Ohio State Medical Association and to express my thanks to the executive staff and secretarial staff for their help."

The members of the Committee are: Carl A. Minning, Clermont County; Jerry L. Hammon, Miami County; Dwight L. Becker, Allen County; George N. Bates, Lucas County; Elden C. Weckesser, Cuyahoga County; Daniel W. Mathias, Summit County; Robert E. Rinderknecht, Tuscarawas County; Jack L. Kraker, Fairfield County; Richard E. Bullock, Vinton County; William R. Graham, Huron County; James C. McLarnan, Knox County, *Chairman*.

By official action, the report of the Resolutions Committee No. 1 as a whole, as amended, was approved by the House of Delegates.

Report of Resolutions Committee No. 2

Dr. Frederick P. Osgood, Lucas County, reported for Resolutions Committee No. 2, of which he was chairman. The report read as follows:

"I would like to thank you and the House for having had the privilege of chairing this Resolutions Committee No. 2. To the eleven resolutions which we heard there was a most active discussion and the committee would like for me, at this opportunity, to express its appreciation for the very cooperative expressions of opinions to the various resolutions.

RESOLUTION NO. 4

Podiatry

(By the Academy of Medicine of Cincinnati)

"The testimony presented developed the ideas which had been presented to such an extent that the Resolutions Committee submits a substitute resolution as follows:

SUBSTITUTE RESOLUTION NO. 4

Podiatry

WHEREAS, There is obvious need for a change in the Medical Practice Act in the area involving chiropody (podiatry), and

WHEREAS, Efforts at the present time have been directed to the State Legislature pursuant to this need; THEREFORE BE IT

RESOLVED, That the Association make efforts to obtain amendments to the Medical Practice Act of the State of Ohio to define legally and clearly the technical boundaries of podiatry to determine what podiatrists may be permitted to do in the State of Ohio."

"The Committee recommends the adoption of Substitute Resolution No. 4 and, Mr. President, I so move."

By official action, the House of Delegates amended Substitute Resolution No. 4 by inserting after the word "That" in the Resolved paragraph the words "the Association make efforts to obtain amendments to" and by striking out the words "be amended" after the word "Ohio".

By official action, Substitute Resolution No. 4 was adopted as amended.

RESOLUTION NO. 5

To Endorse and Promote Legislation for the Establishment of an Air Pollution Control Board

(By the Academy of Medicine of Cincinnati)

WHEREAS, Bills are now pending before the Senate and House of Representatives of the 107th General Assembly, Regular Session 1967-68, and further identified as Senate Bill 31 and H. B. 103, and

WHEREAS, Effective legislation is needed to establish a Board with authority to set standards, adopt reasonable methods of enforcement, and enter into a pact with other states on a reciprocal basis for the purpose of decreasing the pollution of the air, and

WHEREAS, Such legislation is necessary to effectively protect the general public; NOW, THEREFORE, BE IT

RESOLVED, That the Ohio State Medical Association adopt in principle the support of appropriate legislation and instruct the Legislative Committee to take any action deemed necessary to obtain the procurement of legislation that will establish an air pollution control board, AND BE IT FURTHER

RESOLVED, That the administration of the Air Pollution Control Board be under the control, jurisdiction, and guidance of the Department of Health, State of Ohio.

"The Committee recommends the adoption of Resolution No. 5 and, Mr. President, I so move."

By official action, the recommendation of the committee, namely, that Resolution No. 5 be adopted, was approved.

RESOLUTION NO. 7

Group Malpractice Coverage

(By the Summit County Medical Society)

"Resolution No. 7 was the subject of a great deal of discussion. Many areas were presented from the floor which the committee felt could best be embodied in the following substitute resolution:

SUBSTITUTE RESOLUTION NO. 7

Group Malpractice Coverage

WHEREAS, This House of Delegates recognizes the increasing difficulty of some of its members in obtaining

adequate professional liability insurance, NOW, THEREFORE, BE IT

RESOLVED, That the House of Delegates requests The Council of the Ohio State Medical Association to investigate the feasibility of group liability insurance for members of the Ohio State Medical Association, AND BE IT FURTHER

RESOLVED, That a progress report be presented at the 1968 Annual Meeting.

"Mr. President, the Committee recommends the adoption of Substitute Resolution No. 7, and I so move."

By official action, the recommendation of the committee, namely, that Substitute Resolution No. 7 be adopted, was approved.

RESOLUTION NO. 8

Mental Health Centers

(By the Summit County Medical Society)

"Discussion developed the fact that there was an omission in the first RESOLVED of an organization which is vitally interested in the problem. Therefore, the Committee recommends that the first RESOLVED be altered to read as follows:

"RESOLVED, that the OSMA, through its Council and its Committee on Mental Health, investigate all such planning by consultation with the Division of Mental Hygiene of the State of Ohio, the Ohio Psychiatric Association and allied groups, and the component county medical societies where such community mental health centers are planned so as to be cognizant of hazards inherent in the plans, AND BE IT FURTHER"

"With this editorial change, Mr. President, the Committee recommends the adoption of Resolution No. 8, and I so move."

The Second Councilor District presented a substitute resolution in lieu of Resolution No. 8 and in lieu of the Reference Committee's report on Resolution No. 8.

By official action, the House of Delegates amended the final Resolved portion of the substitute resolution by inserting after the word "plans" the words "appear to" and by striking out after the words "State of Ohio" the words "that immediate legal action be taken" and by inserting in lieu thereof the words "The Council investigate and if discussions fail, then take appropriate steps to initiate legal action."

AMENDED SUBSTITUTE RESOLUTION NO. 8

Mental Health Centers

WHEREAS, The OSMA has previously indicated its desire and intent to assume a position of leadership in health programs at all levels, and

WHEREAS, We are now seeing the planning and establishment of community mental health centers as provided by PL 88-164, and

WHEREAS, There is evidence that many of these plans are being developed with little or no professional medical consultation or direction, and

WHEREAS, This method of development will create programs which transgress on the traditional methods of medical practice and hospital medical staff policies and in some instances, are in conflict with the principles of medical ethics and also the statutes of the State of Ohio, and

WHEREAS, A breach of established ethical principles and medical practice statutes will seriously jeopardize the quality of medical care rendered thus depriving many persons of appropriate treatment, NOW, THEREFORE, BE IT

RESOLVED, That the OSMA, through its Council and its Committee on Mental Health, investigate all such planning by consultation with the Division of Mental Hygiene of the State of Ohio, the Ohio Psychiatric Association and allied groups, and the component county medical societies where such community mental health centers are planned so as to be cognizant of hazards inherent in the plans, AND BE IT FURTHER

RESOLVED, That in every instance where the plans will violate the principles of medical ethics that official notification be sent to the American Medical Association and the appropriate federal office to effect the necessary changes in the plan, AND BE IT FURTHER

RESOLVED, That in every instance where the plans appear to violate the statutes of the State of Ohio The Council investigate and if discussions fail, then take appropriate steps to initiate legal action to stop the violation and that notification of this action be sent to the Governor, Attorney General, and the Director of the Department of Mental Hygiene and Correction of the State of Ohio.

By official action, Amended Substitute Resolution No. 8 was adopted.

AMENDED RESOLUTION NO. 9

Additional Ohio Medical Schools

(By the Summit County Medical Society)

WHEREAS, The ratio of physicians to population in the State of Ohio has remained essentially static for the past three years, and

WHEREAS, The increasing complexities of medical practice raise concern for our capacity, without an improvement in this ratio, to continue to provide high quality medical care to the citizens of the State, to preserve the highest professional character of medical practice, and to maintain the traditional doctor-patient relationship, without excessive reliance on ancillary medical personnel, NOW, THEREFORE, BE IT

RESOLVED, That the Ohio State Medical Association continue to recognize its duty in advising and encouraging the government of the State of Ohio to provide adequately for the training of increased numbers of physicians, by instructing The Council of the Ohio State Medical Association to encourage the Ohio General Assembly and the Governor of the State of Ohio to assign top priority to the business of planning for and the beginning of construction of additional medical schools in Ohio by June 1, 1969.

"This resolution, foreseeing, as it does, the need which is present, was enthusiastically endorsed by all persons present. The Committee, however, felt that in the last RESOLVED it would be more appropriate to say "additional medical schools" instead of "two more medical schools."

"Mr. President, with this editorial change, the Committee recommends the adoption of Resolution No. 9, and I so move."

By official action, the recommendation of the committee, namely, that Resolution No. 9, with an amendment to change the wording to "additional medical schools" instead of "two medical schools," be adopted, was approved.

RESOLUTION NO. 12 AND RESOLUTION NO. 30

Education of Nurses

"Resolution No. 12, entitled Education of Nurses, submitted by the Academy of Medicine of Toledo

and Lucas County, and Resolution No. 30, entitled Nursing Education, submitted as an emergency resolution by The Council of the Ohio State Medical Association were considered together. The very obvious content similarity made this combination possible.

"There was a great deal of discussion and a great deal of light was shed on the problem by all the discussants. The Committee felt that the problem presented was adequately covered in Resolution No. 12 and, for this reason, recommends that Resolution No. 30 be accepted for the information of the House of Delegates and that Resolution No. 12 be adopted. Mr. President, I so move."

By official action, the recommendation of the committee, namely, that Resolution No. 30 be accepted for the information of the House and that Resolution No. 12 be adopted, was approved.

Resolution No. 12 reads as follows:

WHEREAS, A serious shortage of nurses now exists in Ohio and the United States, and

WHEREAS, Licensed Practical Nurses with one year of training in bedside nursing, including women of varied backgrounds and ages who might be unavailable or ineligible for other professional nurse training programs are now helping to correct the shortage of nurses by performing a substantial part of hospital nursing care, and

WHEREAS, It is desirable for selected professional nurses to take advanced academic training for a baccalaureate or higher degree, nevertheless the major part of hospital nursing care can be given by diploma-registered nurses or licensed practical nurses, and

WHEREAS, The National League for Nursing, and the American Nurses' Association, with support by the Ohio Board of Nursing Education and other similar State Boards, are proposing that all nursing education be moved out of hospital schools into the higher educational system, requiring two years of Junior or Community College for Associate Nurses who would eventually displace the Licensed Practical Nurses, and four years of college with baccalaureate degree for Registered Nurses, and

WHEREAS, This proposal would restrict and limit the number of nurses available for care of the sick, increasing the already critical shortage of nurses, and would add to hospital costs by forcing hospitals to employ higher salaried nurses in place of practical nurses, THEREFORE, BE IT

RESOLVED, That the Ohio State Medical Association support the present system of hospital-based diploma schools of nursing and practical nursing, and that steps be taken to enlarge their enrollment in order to provide enough nurses with bedside training to meet the country's needs, to graduate nurses who are competent to assume the responsibilities of floor nurses in hospitals, and to do this at a reasonable cost, AND BE IT FURTHER

RESOLVED, That the Ohio State Medical Association and the American Medical Association use their influence to prevent a proposed educational program which would reduce the number and the practical competency of nurses.

RESOLUTION NO. 18

Certification

(By the Columbus Academy of Medicine)

"Resolution No. 18 was next considered.

"The problems which have been created by the present regulations pursuant to Public Law 89-97 have made this type of resolution inevitable. The Committee in its deliberations was confirmed in its opinion that a change should be made in the first

WHEREAS, which would necessitate a change in the title to "Support of OSMA and AMA Policies." The change in the first WHEREAS is the insertion of a comma after the word "Association" in the sixth line and the deletion of the words "relative to certification and recertification of medical necessity," which makes the first WHEREAS read as follows:

"WHEREAS, There have been instances in Ohio of members of the Ohio State Medical Association being deprived of hospital privileges as a result of strict adherence to the policies laid down by the Ohio State Medical Association and the American Medical Association, NOW, THEREFORE, BE IT

"This change broadens the resolution but the committee feels it makes the intent much stronger.

"Mr. President, the Committee recommends the adoption of Resolution No. 18, as editorially modified, and I so move."

By official action, the recommendation of the committee, namely, that Resolution No. 18 be adopted as editorially modified, was approved.

The resolution as approved reads as follows:

EDITORIALLY CHANGED RESOLUTION NO. 18

Support of OSMA and AMA Policies

WHEREAS, There have been instances in Ohio of members of the Ohio State Medical Association being deprived of hospital privileges as a result of strict adherence to the policies laid down by the Ohio State Medical Association and the American Medical Association; NOW, THEREFORE, BE IT

RESOLVED, That the Ohio State Medical Association establish a permanent committee to investigate such instances and devise effective methods of supporting the stand of physicians so affected.

RESOLUTION NO. 25

Centurion Committee

(By the Huron County Medical Society)

"There was a very active discussion on the part of members of the society and its consultants. The Committee feels that there are areas of purview into which the Ohio State Medical Association should not direct its efforts, sympathies in the area of the resolution to the contrary notwithstanding. After extensive deliberation, pursuant to prolonged discussion from the floor, the Committee registered an unfavorable opinion toward Resolution No. 25. The Committee acted by prolonging the discussion into the second day of hearings to adequately permit complete exposition of this substance.

"By unanimous action, the Committee recommends that Resolution No. 25 NOT be adopted. Mr. President, I so move."

By official action, the recommendation of the committee, namely, that Resolution No. 25 NOT be adopted, was approved.

RESOLUTION NO. 26

Out-Patient Diagnostic Procedures

(By the Huron County Medical Society)

"Resolution No. 26 was heard next by the Committee. It was obvious from the discussion that there was sympathy with the ideas expressed in this resolu-



At the Inaugural Session of the House of Delegates, this section was reserved for officers, Councilors, Past Presidents, former Councilors, AMA Delegates and Alternates, Presidents of County Medical Societies, distinguished visitors and persons to be honored.



Past Presidents of the Association were honored at a dinner meeting of The Council on Tuesday evening of the Annual Meeting week. Those present, from left, are: Dr. Robert S. Martin, Dr. Merrill D. Prugh, Dr. Edwin H. Artman, Dr. George W. Petznick, Dr. Horatio T. Pease, Dr. Richard L. Meiling, Dr. Lawrence C. Meredith (now the Immediate Past President), Dr. L. Howard Schriver, Dr. Frank H. Mayfield, Dr. Harve M. Clodfelter, Dr. Henry A. Crawford, and Dr. Robert E. Tschantz.



This is the Montgomery County Medical Society Glee Club, directed by Dr. William J. Lewis, Jr., as it entertained at the Special Inaugural Session of the House of Delegates.

tion. The Committee was advised that there are presently negotiations being conducted and that the solution to the problems stated are being implemented. It was further reported that there are policies available and widely held which cover the areas concerned.

"For the above reasons, the Committee recommends that Resolution No. 26 be NOT adopted and, Mr. President, I so move."

By official action, the recommendation of the committee, namely, that Resolution No. 26 NOT be adopted, was approved.

RESOLUTION NO. 29

Medical Care Fees for Military Dependents (By the Summit County Delegation)

"Resolution No. 29, submitted as an emergency resolution by the Summit County delegation, was next considered by the Committee.

"There was complete accord with the ideas expressed in this resolution and for this reason the Committee recommends its adoption. Mr. President, I so move.

By official action, the recommendation of the committee, namely, that Resolution No. 29 be adopted as presented, was approved. (See page 941 for text of resolution.)

"Mr. President, I would like to move the adoption of the Report of Resolutions Committee No. 2 as a whole, as amended.

"I would be remiss if I did not publicly express my sincere gratitude to all members of the Ohio State Medical Association and its affiliated experts who enabled the Committee to arrive at the conclusions which it did. I wish further to express my delight at having been afforded the cooperation of so many excellent co-workers."

The members of the Committee are as follows: Charles A. Sebastian, Hamilton County; James G. Tye, Montgomery County; Donald R. Brumley, Hancock County; Robert A. Irvin, Lake County; Maurice F. Lieber, Stark County; Robert R. Johnson, Coshoc-ton County; Kenneth E. Bennett, Washington County; Albert M. Shrader, Pike County; Jasper M. Hedges, Pickaway County; Albert Burney Huff, Wayne County; F. P. Osgood, Lucas County, *Chairman*.

By official action, the report of Resolutions Committee No. 2 as a whole, as amended, was approved.

Report of Resolutions Committee No. 3

"Resolutions Committee No. 3 considered eight resolutions. Discussion was thorough, audience participation was considerable and general agreement was obtained in all resolutions. The Committee gave full consideration to the helpful information provided by the audience participation.

RESOLUTION NO. 16

Quality Medical Care

(By the Second Councilor District Delegates)

The Committee proposed an Amended Resolution No. 16, as follows:

AMENDED RESOLUTION NO. 16

Quality Medical Care

WHEREAS, The physicians of Ohio, to the best of their ability, render maximum quality medical care to their patients; and

WHEREAS, Organized medicine is continuously devoted to the provision of maximum quality medical care; and

WHEREAS, Publicity received by organized medicine of the State of Ohio does not always demonstrate to the people of Ohio the dedication of doctors to the principles of maximum quality care for everyone; THEREFORE, BE IT

RESOLVED, That the House of Delegates of the Ohio State Medical Association, speaking for the members of organized medicine in the State of Ohio, does hereby reaffirm their dedication to the highest principles and practices of medical care for all people.

"The Committee recommends the adoption of Amended Resolution No. 16 and, Mr. President, I so move."

By official action, the recommendation of the committee, namely, that Amended Resolution No. 16 be adopted, was approved.

RESOLUTION NO. 1

Handling of Emergency Victims

(By the Wayne County Medical Society)

After a thorough discussion, the Committee proposed that Resolution No. 1 be amended as follows:

AMENDED RESOLUTION NO. 1

Handling of Emergency Victims

WHEREAS, A recent study of traffic fatalities indicate that accidents in rural communities have a higher percentage of loss of life than similar accidents in urban areas, and

WHEREAS, The higher case fatality ratio in rural areas seems to be related to the inability to provide adequate first aid procedure and of transporting the person to a hospital within a reasonable length of time. NOW, THEREFORE, BE IT

RESOLVED, That the Ohio State Medical Association adopt and help to implement, through the county medical societies, the five point program listed below to provide first aid training on a wider scope for rural Ohioans and swifter handling of emergency victims by:

1. Coordination of the efforts of rural communities with adjacent towns or urban centers in analyzing existing patterns of response to medical emergencies.

2. Inauguration by rural and urban communities of a medical service area program for emergency medical transportation facilities and health personnel.

3. Adoption by rural and urban communities where practical, of standards for ambulance equipment, personnel and operation, liability insurance requirements and maintenance of records.

4. Provision by rural and urban communities of a program of advanced first aid instruction for the nonmedical people most frequently called in rural emergencies, especially police, sheriffs, and ambulance crews.

5. Development by rural and urban communities of a continuing campaign directed toward first aid instruction for rural families and, particularly, young people through the schools, youth organizations, and other educational channels.

"The Committee recommends the adoption of this

amended resolution and, Mr. President, I so move."

By official action, the House editorially amended the Amended Resolution No. 1 and approved the recommendation of the committee, namely, that Amended Resolution No. 1 be adopted.

RESOLUTION NO. 2

AAPS Essay Contest

(By the Columbus Academy of Medicine)

BE IT RESOLVED, that the House of Delegates of the Ohio State Medical Association endorse the Essay Contest of the Association of American Physicians and Surgeons with the titles: (1) The Advantages of the American System of Private Medical Care and (2) The Advantages of the American Free Enterprise System.

"This has been a traditional resolution before the Association. No objections were heard and this Committee unanimously recommends its adoption and, Mr. President, I so move."

By official action, the recommendation of the committee, namely, that Resolution No. 2 be adopted as presented, was approved.

RESOLUTION NO. 11

Changes in Regulations by the Ohio State Board of Health

(By the Academy of Medicine of Toledo and Lucas County)

"The Committee took the privilege of retitling the resolution 'Changes in Regulations by the Ohio Department of Health,' since Ohio Department of Health is the correct name."

AMENDED RESOLUTION NO. 11

Changes in Regulations by the Ohio Department of Health

WHEREAS, A serious shortage of hospital beds exists in most of Ohio, resulting in long periods of waiting for admission for medical or surgical care, and

WHEREAS, Construction of new hospital beds to accommodate these needs is costly and would be delayed for years, and

WHEREAS, The number of patients admitted to obstetrical departments is everywhere decreasing leaving large numbers of maternity beds unoccupied, and

WHEREAS, Studies by the Chicago Board of Health and elsewhere have proven the safety of mixing obstetrical and noninfectious gynecological patient.

WHEREAS, The Illinois Hospital Licensing Board has changed its rules for licensing and now allows mixing under controlled conditions, and

WHEREAS, The Joint Commission on Accreditation of Hospitals already allows the use of unused obstetrical space for certain gynecological patients, and

WHEREAS, Use of such unused beds, with proven safety, would immediately increase effective hospital capacity throughout Ohio at no outlay of cash since most hospitals have unused maternity beds, THEREFORE, BE IT

RESOLVED, That the Ohio State Medical Association support measures to effect the necessary change in regulations by the Ohio Department of Health to permit the use of maternity beds by suitable gynecological patients, AND BE IT FURTHER

RESOLVED, That the Ohio State Medical Association urge the Ohio Department of Health, the Ohio Hospital Association and the Hospital Planning Associations throughout Ohio to support whatever legislation is necessary to provide more hospital beds in Ohio.

"The Committee recommends the adoption of

Amended Resolution No. 11 and, Mr. President, I so move."

By official action, the recommendation of the committee, namely, that Amended Resolution No. 11 be adopted, was approved.

RESOLUTION NO. 14

Smoking and Health

(By the Columbus Academy of Medicine)

"This Resolution was thoroughly discussed by the Committee and it was the unanimous opinion that while the Ohio State Medical Association had no right to interfere with the personal habits of its members, yet it felt that the influence of the members of this organization is important enough to submit this Resolution with only minor changes in the Resolved areas. Consequently, in order that we may save time, only this portion of the Resolution is now read.

RESOLVED, That members of the Ohio State Medical Association officially recognize their opportunities and responsibilities in this important field by setting a good example as regards cigarette smoking, and by participating actively in their practices and in community programs to influence and persuade people not to smoke.

"The Committee recommends the adoption of the amended Resolution No. 14 and, Mr. President, I so move."

By official action, the House adopted the following additional paragraph and adopted Amended Resolution No. 14 in accordance with the recommendation of the committee:

"AND BE IT FURTHER

"RESOLVED, That the delegates of the Ohio State Medical Association introduce a similar resolution in the next session of the House of Delegates of the American Medical Association."

AMENDED RESOLUTION NO. 14

Smoking and Health

WHEREAS, Cigarette smoking has been established as having a causal relationship with death and disability from lung cancer, coronary heart disease, emphysema and chronic bronchitis, and

WHEREAS, Death and disability from these diseases cause needless pain and anguish and millions of dollars in lost wages, medical expenses, and hospitalization, and

WHEREAS, The conclusion of the Smoking and Health Advisory Committee to the Surgeon-General of the United States Public Health Service is that:

"Cigarette smoking is a health hazard of sufficient importance in the United States to warrant appropriate remedial action," and

WHEREAS, The following national organizations agree with the conclusion of the Smoking and Health Advisory Committee: American Association for Health, Physical Education, and Recreation; American Association of School Administrators; American Cancer Society; American College Health Association; American Dental Association; American Heart Association; American Pharmaceutical Association; American Public Health Association; American School Health Association; Association of State and Territorial Health Officers; Department of Classroom Teachers of The National Education Association; National Congress of Parents and Teachers; National League for Nursing; National Tuberculosis Association; U. S. Chil-

dren's Bureau; U.S. Office of Education; U.S. Public Health Service. Affiliate Membership: Boys' Clubs of America; National Board of Young Men's Christian Association; National Board of Young Women's Christian Association; National Student Nurses Association; Public Health Cancer Association of America. NOW, THEREFORE, BE IT

RESOLVED, That members of the Ohio State Medical Association officially recognize their opportunities and responsibilities in this important field by setting a good example as regards cigarette smoking, and by participating actively in their practices and in community programs to influence and persuade people not to smoke; AND BE IT FURTHER

RESOLVED, That the delegates of the Ohio State Medical Association introduce a similar resolution in the next session of the House of Delegates of the American Medical Association.

RESOLUTION NO. 20 Measles Immunization

(By the Mahoning County Medical Society)

"The Committee was in full accord with the intent of this resolution and amended only the Resolved portion of the resolution as follows:

"RESOLVED, That the Ohio State Medical Association advocate that all children be immunized against measles at the earliest suitable age"

"The Committee recommends the adoption of this Amended Resolution No. 20 and, Mr. President, I so move."

A motion to substitute the original Resolution No. 20 for the report of the committee was not adopted. By official action, the recommendation of the committee, namely, that Amended Resolution No. 20 be adopted, was approved.

AMENDED RESOLUTION NO. 20 Measles Immunization

WHEREAS, An effective vaccine for the control of Measles (Rubeola) has been available to physicians and their patients for more than three years, and

WHEREAS, The medical profession, the Surgeon General of the United States, and various official Health Departments and agencies have agreed on the importance and necessity of eradicating this disease, and

WHEREAS, The state of Ohio has made it mandatory that children receive certain immunizations for the prevention of diphtheria, whooping cough, tetanus, smallpox, and poliomyelitis, before entering school, THEREFORE, BE IT

RESOLVED, That the Ohio State Medical Association advocate that all children be immunized against measles at the earliest suitable age.

RESOLUTION NO. 21 Delinquent State Accounts

(By the Huron County Medical Society)

"While the Committee was in sympathy with the seriousness of this resolution it was the unanimous opinion that the intent of the resolution could not be fulfilled and furthermore that such a resolution would not be within the boundaries of current medical ethics. This is substantiated by an opinion from the American Medical Association's Judicial Council. Therefore, the Committee recommends that Resolution No. 21 NOT be adopted and, Mr. President, I so move."

By official action, the recommendation of the

committee, namely, that Resolution No. 21 NOT be adopted, was approved.

RESOLUTION NO. 24 Freedom

(By the Huron County Medical Society)

"The Committee gave this resolution much consideration. We agree with the principles embodied in the resolution. However, much if not most of the philosophy and possibilities of practical application of this resolution are expressed in the emergency resolution assigned to Resolution Committee No. 1 which was introduced on the floor of the House of Delegates at the opening meeting. Therefore, the Committee unanimously recommends that this resolution NOT be adopted and, Mr. President, I so move."

By official action, the recommendation of the committee, namely, that Resolution No. 24 NOT be adopted, was approved.

"Mr. President, I move the adoption of the Report of Resolutions Committee No. 3 as a whole.

"The committee is most appreciative of the testimony and cooperation given by interested members at the hearings. The chairman wishes to express appreciation to the committee members who gave so generously of their time and wisdom. The chairman would also like to express appreciation for the excellent secretarial help from the headquarters office."

The members of the Committee are: Robert P. Johnson, Butler County; Maurice M. Kane, Darke County; Walter A. Daniel, Seneca County; William J. Neal, Fulton County; William F. Boukalik, Cuyahoga County; Leonard P. Caccamo, Mahoning County; Glenn C. Dowell, Carroll County; Carl E. Spragg, Muskingum County; Joseph T. Gohmann, Scioto County; Charles W. Pavey, Franklin County; James T. Stephens, Lorain County; *Chairman*.

By official action, the report of Resolutions Committee No. 3, as a whole, as amended, was approved.

AMA President-Elect Introduced

Dr. Milford O. Rouse, Dallas, Texas, President-Elect of the American Medical Association, was escorted to the rostrum and was presented to the House. Dr. Rouse addressed the House.

Election of President-Elect

Dr. Meredith called for nominations for the office of President-Elect. Dr. William J. Lewis, Montgomery County, placed in nomination Dr. Theodore L. Light, Montgomery County, Councilor of the Second District. The nomination was seconded by Dr. P. John Robechek, Cuyahoga County, Councilor of the Fifth District. There being no further nominations, the secretary was instructed to cast the unanimous ballot of the House for Dr. Light. Dr. Light was declared elected President-Elect and was es-

corted to the rostrum where he addressed the House of Delegates.

Election of Councilors

Dr. Fred P. Berlin, Allen County, acting for the chairman of the Nominating Committee, Dr. James O. Barr, Cuyahoga County, presented the following report:

Second District

As Councilor of the Second District to succeed Dr. Theodore L. Light, Dayton, who was elected President-Elect, the committee placed in nomination Dr. George J. Schroer, Sidney. There being no further nominations, by official action the nominations were closed and Dr. Schroer was declared elected Councilor of the Second District for a term of two years, 1967-1968 and 1968-1969.

Fourth District

As Councilor of the Fourth District to succeed himself, the committee placed in nomination Dr. Robert N. Smith, Toledo. The nomination being duly seconded, and there being no further nominations from the floor, by official action the nominations were closed and Dr. Smith was declared re-elected Councilor of the Fourth District for a term of two years, 1967-1968 and 1968-1969.

Sixth District

As Councilor of the Sixth District to succeed himself, the committee placed in nomination Dr. Edwin R. Westbrook, Warren. The nomination being duly seconded, and there being no further nominations from the floor, by official action the nominations were closed and Dr. Westbrook was declared re-elected Councilor of the Sixth District for a term of two years, 1967-1968 and 1968-1969.

Eighth District

As Councilor of the Eighth District to succeed Dr. Robert C. Beardsley, Zanesville, who had served the maximum number of terms under the Constitution and Bylaws, the committee placed in nomination Dr. James A. Quinn, Jr., Newark. The nomination being duly seconded, and there being no further nominations from the floor, by official action the nominations were closed and Dr. Quinn was declared elected Councilor of the Eighth District for a term of two years, 1967-1968 and 1968-1969.

Ninth District

The committee placed in nomination Dr. Oscar W. Clarke, Gallipolis, as a member of The Council from the Ninth District to serve for one year—the unexpired term of Dr. George N. Spears, Ironton, who resigned as a member of The Council. Dr. Clarke was selected by The Council on September 11, 1966 to serve as Councilor of the Ninth District until the 1967 Annual Meeting due to the resignation of Dr. Spears. There being no further nominations, by official action the nominations were



As President of the host Academy of Medicine of Columbus and Franklin County, Dr. Tom F. Lewis officially opens the first session of the House of Delegates and guests to Columbus.



The gavel is presented to Incoming President Robert E. Howard, right, by Immediate Past President Henry A. Crawford.



Dr. Henry A. Crawford, right, Cleveland, retiring as Immediate Past President after seven years on The Council, is presented a plaque in appreciation of his services to the Association. Outgoing President Lawrence C. Meredith makes the presentation.

closed and Dr. Clarke was declared elected Councilor of the Ninth District for one year—1967-1968.

Tenth District

As Councilor of the Tenth District to succeed himself, the committee placed in nomination Dr. Richard L. Fulton, Columbus. The nomination being duly seconded, and there being no further nominations from the floor, by official action the nominations were closed and Dr. Fulton was declared re-elected Councilor of the Tenth District for a term of two years, 1967-1968 and 1968-1969.

Election of Treasurer

For the office of Treasurer the committee placed in nomination Dr. James L. Henry, Grove City, to succeed Dr. Philip B. Hardyman, Columbus, who was ineligible for re-election, having completed two terms as Treasurer.

There being no further nominations from the floor, by official action the nominations were closed and Dr. Henry was declared elected Treasurer for a term of three years — 1967-1968, 1968-1969, 1969-1970.

AMA Delegates and Alternates

The Nominating Committee then placed in nomination the following for delegates to the American Medical Association for a term of two years beginning January 1, 1968; Drs. Philip B. Hardyman, Columbus; John A. Budd, Cleveland; Richard L. Meiling, Columbus; Charles A. Sebastian, Cincinnati; Frederick P. Osgood, Toledo. There being no further nominations, the nominations were closed and Dr. Hardyman was elected and Drs. Budd, Meiling, Sebastian, and Osgood were re-elected delegates to the AMA for a term of two years beginning January 1, 1968 and expiring on December 31, 1969.

For the position of alternate delegate to Dr. Hardyman, the committee placed in nomination Dr. Lawrence C. Meredith, Elyria. Dr. Jack L. Kraker, Lancaster, was nominated from the floor by Dr. Kenneth E. Bennett, Washington County, and seconded by Dr. Carl A. Minning, Clermont County. There being no further nominations, an official ballot was conducted and Dr. Meredith was declared elected alternate delegate to Dr. Hardyman for a term beginning January 1, 1968 and expiring December 31, 1969.

For the position as alternate delegate to Dr. Richard L. Meiling, Columbus, the committee placed in nomination Dr. Frank F. A. Rawling, Toledo. Dr. James G. Roberts, Akron, was placed in nomination by Dr. Edwin R. Westbrook, Trumbull County, and was seconded by Dr. Daniel W. Mathias, Summit County. There being no further nominations, an official ballot was conducted and Dr. Rawling was declared elected alternate delegate to Dr. Meiling for a term beginning January 1, 1968 and expiring December 31, 1969.



Certificates of Humanitarian Service were presented to several physicians who served under the Volunteer Physicians for Vietnam program. President Meredith here congratulates and commends one of the recipients, Dr. James B. Patterson, of Lorain, after presenting the certificate.



Outgoing President Meredith, left, relinquishes the gavel to Incoming President Howard.



Dr. Crawford, left, relinquishes his office on The Council to the new Immediate Past President, Dr. Meredith.

Dr. Frank H. Mayfield, Cincinnati, was elected to succeed Dr. J. Robert Hudson, Cincinnati, as alternate delegate to Dr. Sebastian for a term beginning January 1, 1968 and expiring December 31, 1969.

Dr. P. John Robeck, Cleveland, and Dr. Robert N. Smith, Toledo, were re-elected alternate delegates for a term beginning January 1, 1968 and expiring December 31, 1969.

Dr. James C. Good, Columbus read to the House of Delegates, with the consent of the House, a statement on methods of electing the officers of the Ohio State Medical Association.

Closing Ceremonies

Dr. Meredith then presented the gavel to Dr. Howard and Dr. Meredith received from Dr. Howard the Past President's pin. Dr. Henry A. Crawford, Cleveland, retiring as Immediate Past President, invited Mrs. Meredith to the rostrum and presented to Dr. and Mrs. Meredith an engraved tray. Also, a special certificate of honor was presented to Dr. Meredith for his service to the Association.

Committees Named

Dr. Howard made the following committee appointments which were officially approved by the House of Delegates:

Committee on Education—Dr. Thomas E. Rardin, Columbus, reappointed chairman for the ensuing year; Dr. Goffredo S. Accetta, Cincinnati, appointed for a five-year term, 1967-1972.

Judicial and Professional Relations Committee—Dr. Homer A. Anderson, Columbus, appointed chairman for the ensuing year; Dr. Carl W. Koehler, Cincinnati, appointed for a five-year term, 1967-1972.

Committee on Public Relations and Economics—Dr. Frederick P. Osgood, Toledo, reappointed chairman for the ensuing year; Dr. Clyde Chamberlin, Hamilton, appointed for a five-year term, 1967-1972.

Committee on Scientific Work—Dr. Samuel Saslaw, Columbus, reappointed chairman for the ensuing year; Dr. N. J. Giannestras, Cincinnati, appointed for a five-year term, 1967-1972; Dr. John A. Prior, Columbus, appointed for a five-year term, 1967-1972.

Appreciation Expressed

Members of the House of Delegates expressed appreciation to the committees and staffs of the Columbus Academy of Medicine, to the Auxiliary, members of the news media, managements of the Columbus hotels, and to all others who contributed to the success of the 1967 Annual Meeting.

Dr. Jack L. Kraker, Fairfield County, asked for the privilege of the floor for the purpose of congratulating Dr. Meredith on his service as president and on his election as alternate delegate to the AMA House of Delegates.

The House of Delegates then adjourned sine die.

Attest: HART F. PAGE
Executive Secretary

Roll Call of House of Delegates
1967 Annual Meeting

County	Delegate	First Session	Final Session	County	Delegate	First Session	Final Session
FIRST DISTRICT				THIRD DISTRICT			
ADAMS	Francis L. Stevens	Present	Present	MIAMI	J. L. Hammon	Present	Present
BROWN	John R. Donohoo	Present	Present	MONTGOMERY	John R. Brown	Present	Present
BUTLER	Willis F. Hume	Present	Present		Robert A. Bruce	Present	Present
	Robert P. Johnson	Present	Present		Mason Jones	Present	Present
CLERMONT	Carl A. Minning	Present	Present		W. J. Lewis	Present	Present
CLINTON	Edmond K. Yantes	Present	Present		William M. Porter	Present	Present
HAMILTON	William C. Ahlering	Present	Present		Franklin L. Shively, Jr.	Present	Present
	Frank P. Cleveland	Present	Present	PREBLE	J. Richard Strawsburg	Present	Present
	Joseph G. Crotty	Present	Present		James G. Tye	Present	Present
	Robert S. Heidt	Present	Present	SHELBY	C. J. Brian	Present	Present
	Harry K. Hines	Present	Present		George J. Schroer	Present	Present
	Daniel V. Jones	Present	Present	FOURTH DISTRICT			
	Carl W. Koehler	Present	Present	ALLEN	Dwight L. Becker	Present	Present
	Elmer R. Maurer	Present	Present		Fred P. Berlin	Present	Present
	Marvin McClellan	Present	Present	AUGLAIZE	Robert S. Oyer	Present	Present
	Arthur W. Nadler	Present	Present	CRAWFORD	Horace B. Newhard	Present	Present
	Clyde S. Roof	Present	Present	HANCOCK	Donald R. Brumley	Present	Present
	Charles A. Sebastian	Present	Present	HARDIN	Clarence L. Johnson	Present	Present
	Stanley D. Simon	Present	Present	LOGAN	Charles A. Browning	Present	Present
	Albert E. Thielen	Present	Present	MARION	Albert M. Mogg	Present	Present
	Robert M. Woolford	Present	Present	MERCER	James J. Otis	Present	Present
HIGHLAND	Clifford G. Foor	Present	Present	SENECA	Walter A. Daniel	Present	Present
WARREN	Thomas E. Fox	Present	Present	VAN WERT	Edwin W. Burnes	Present	Present
SECOND DISTRICT				WYANDOT	Donald P. Smith	Present	Present
CHAMPAIGN	Isador Miller	Present	Present	FIFTH DISTRICT			
CLARK	John W. Rechsteiner	Present	Present	DEFIANCE	Charles E. Jaeckle	Present	Present
	Ernest H. Winterhoff	Present	Present	FULTON	William J. Neal	Present	Present
DARKE	Maurice M. Kane	Present	Present	HENRY	Edwin C. Winzeler	Present	Present
GREENE	Roger C. Henderson	Present	Present				

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The compact, self-powered Amplifier clips to the front of your 500 Viso, allowing diagnostic PCG's, ECG's, or the PCG superimposed on the ECG, to be recorded. Switch-selected filter positions of 50, 100, 250 and 500 Hz (cps) permit excellent recording clarity and separation of the frequency range of interest. In addition, the Amplifier is supplied with an Audiophone to give you a highly efficient electronic stethoscope, with separate controls for listening and recording. (As a teaching tool, the Amplifier and ECG let the user see the sounds recorded, *hear* them, and correlate the two with the ECG.)

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President's Address . . .

"If There Is Yet Honor in the Practice of Medicine . . ."

By LAWRENCE C. MEREDITH, M.D., Elyria

FOR A CHILD, a year is forever . . . immortality in his hand. For a young adult a year is a decade. For the busy practitioner a year can be a month . . . for the President of a State Medical Association, a year is the equivalent of crossing a narrow, but busy street: A few steps and the "walk" light flashes, "Don't Walk" . . . Run!

A brief three-hundred-sixty-five days ago, my inaugural address included reference to areas of organizational weakness such as my belief that there has grown an urgent need to redistrict. The exploration of this need, and the presentation of sound recommendations to this year's House of Delegates meeting, I deeply felt, if accepted, would provide better representation and give an opportunity for more men of ability to serve in official roles. This and many other of my goals have not been accomplished.

I seek no excuse for these failures. The "run light" flashed with the passage of the gavel!

This has been a year of much greater transition, of much greater stress, than I could then anticipate. Daily since July 1, 1966, at the onset of Medicare, the conflicts with our announced policies and traditional ethics usurped the attention of both individual physician and the association. In addition to the struggle to provide care honorably within conflicting provisions of Title XVIII, we have been forced into an intensive search to ferret out conflicting provisions of such additional federal legislation as 89-4, the Appalachia Development Act; 89-239, Heart, Cancer, and Stroke; 89-749, Comprehensive Health Care — socialistically oriented legislation which seemed then, and seems now, to present a question that can be stated as a mathematical equation. Thusly, "is the threat to the voluntary sector of medicine posed by Part A and Part B of Title XVIII, greater, lesser, or equal to the threat posed by Title XIX? Or is the sum of these greater, lesser, or equal to the threat of 89-4, 89-239 and 89-749?"

The Principle Involved

The Ohio State Medical Association is an association of doctors of medicine . . . not mathematicians! Our solution to this equation has been, and will continue to be, predicated upon the belief that where

such legislation violates the direct billing principle, violates free choice, violates physician-patient relationship . . . such legislation is bad. Where such legislation requires urgent and extensive amendments, it is bad. It has been shown by experience elsewhere that "no amount of tinkering and patching at points of immediate breakdown will provide a fundamental cure for the bad original design." Thus in brief: Where such legislation threatens greater control of the physician than now specified by law, where it threatens diminishing personal attention for the patient, where it may decrease the time reasonably required, both didactically and clinically, to achieve optimum professional judgment, and where it requires hasty patchwork amendments . . . the sum of such an equation is bad — it is malignant!

As one analyzes the equation, which represents Mr. Wilbur Cohen's plan to control health care, it is possible, also, to visualize two crosses. The first, and more immediate formed by the vertical extension of age coverage under Medicare, and the cross bar formed by the proposed expansion of services horizontally. The second cross formed by the vertical extension of educational control from core training center to satellite health care station and the horizontal bar of this cross — a proposed vast expansion of ancillary, paramedical personnel.

Glitter of Something-for-Nothing

If the people of these United States fail to see that quality and amount of personal attention may decrease inversely to the amount they are taxed to support general health care; if they are blinded by a "get something for nothing" philosophy; if the physician is misled at this time by absence of federal restrictions; if the physician withdraws his concern — if both community conscience, and the duty to protect that conscience, lead us not to communicate our apprehension and criticism to Congress — this tacit approval will permit "creative federalism" to superimpose the two crosses. The next few years then will witness a great double cross on the health care of the country, and upon this cross another aspect of our democratic freedom will be crucified!

My duty as President in this year of transition and conflict has been to lead and to encourage members of this Association in their struggle to prevent this double cross. I have urged that we not accept as

Presented before the House of Delegates of the Ohio State Medical Association on May 16, 1967. For the report of the Committee on the President's Address, in the official proceedings of the House of Delegates, beginning on page 942.

solutions to the mathematical equation compromise which will permit the establishment of precedent. Precedent, which will limit voluntary practice, ultimately will enslave the profession and enslave the patients. I have lived with the motto: "If there is yet honor in the practice of medicine, there is honor in the fight to preserve it."

I do not feel that a day by day, week by week, or month by month summation of my year can fully convey my gratitude for those members who share this motto, nor can I fully give adequate expression of my personal appreciation for their personal sacri-



Dr. Lawrence C. Meredith delivers the President's Address before the Inaugural Session of the House of Delegates.

fices and dedication to ethical principles. I can simply state that Ohio physicians have displayed exemplary response in answer to our call to eliminate the exculpatory civil rights oath, to resist the assignment method, and to fight against inclusion as hospital-bound specialists.

Other Inroads on Medicine

But the propulsion and the threat of control of medicine by "creative federalism" has not been the sole challenge this year. Labor and management have, with Blue Cross, continued to barter and sell physicians' services without consulting the profession. Blue Cross has fought to include physicians' services in its contracts. Hospitals have continued in their messianic drive to become identified as citadels of community health care, even though 95 per cent of such care is now rendered in the offices of the practicing physicians. Paramedical associations have conspired to gain greater rights to practice pseudo-medicine, when such rights purportedly easing a medical manpower shortage, would, through lack of medical

training, and would, through lack of clinical judgment, actively mislead the public.

The Positive Side

This Association has remained firm in its stand against such inroads, yet we have not been solely defensive, negative, or noncreative. Let me refer to a few of many actions which have been positive and progressive:

At the County Level: Summit County has created and up-dated sound programs pertaining to emergency room procedure and contract review. Lucas County was the second County Medical Society in the United States to ask for and participate in an analysis and review by an outside team, to seek thereby rejuvenation of physician participation and improvement of community responsiveness. It has established guidelines for community, physician, and new medical school interaction. Stark County has recently made a significant and healthy break-through in the expanding challenge to integrate osteopathy and thus unify community health care.

Our State Committees: The Committee on Maternal Health completed its tenth year of study. Its report, summarizing a decade of devotion and scientific deliberation, can show physician and public alike that nonfederally funded, voluntary action by physicians can dramatically reduce maternal mortality!

Through the devotion of our legislative committee and through OMPAC, Ohio physicians played a vital role in the November, 1966, elections. Their success contributed greatly to the significant complexion change of the 90th Congress. Yet, while referring to such a success, I must call to your attention that OMPAC membership lags behind last year's total. This apathy today is tomorrow's indictment: "Too little — too late."

A Third Committee: The newly created Government Medical Care Programs Committee, whose studies have been published for your information, has functioned to supply us with fact, insight, and forward-looking recommendations concerning all state and federal programs relating to health care. It has enabled Council to act aggressively in legislative and regulatory problems . . . this occurred while the AMA has in many areas remained silent regarding its position and policy.

Your Council: Council has adopted a solid stand in favor of competition between the Industrial Commission of Ohio and private enterprise — independent insurance companies desirous of writing such competitive insurance.

The Council has, with the Ohio Hospital Association, cosponsored a first state level "chiefs of staff meeting." This was held at Atwood Lodge in November, 1966.

Council has announced forward looking policy statements to guide physicians in direct billing, in

hospital utilization, in dealing with Appalachia, Title XVIII and Title XIX.

Council, in conjunction with the State Medical Board, has actively sponsored much needed amendments to strengthen the Ohio Medical Practice Act and to better protect the public.

Council has recently, together with its Committee on Legislation, held the first, of what I hope will be many, visitations by members of our Association to Ohio congressmen in Washington.

Doctors and Politics

How effective was our Washington visitation? Let me quote directly from "Ohio News Service," a newsletter published here in Columbus for businesses, professions and manufacturers. The April 17, 1967, issue stated:

"Doctors and politics — Associations could get some fine pointers on how to play the exciting game of politics from the doctors. They've come a long way politically. Politicians just now are waking up to the reality that the 'men in white' know how to influence people and win votes.

"In Washington last week, the doctors held a number of sessions with their congressmen. Ohio State Medical Association representatives were there, well organized and armed with the proper medicine. They visited members of the Ohio (congressional) delegation. Held private talks and then special meetings.

"One congressman said the Ohio Medical group is one of the best organized, most knowledgeable and best informed on legislative matters. 'And what's more,' he added, 'the representatives have convincing arguments to influence anyone dealing in legislation.'"

There is a great temptation to continue, for, in such a summation, the positive acts, the countless hours spent in your behalf by members, Council, all our committees, and the members of our fine headquarters' staff . . . deserve review and high commendation . . . but time will not permit . . . the "Don't Walk — Run" light is flashing! Even now, while expressing my personal and sincere gratitude for all of those Ohio physicians who have recognized the need and the honor implied by the fight . . . I urge that we must look ahead. This is no time for any physician to question "Why must we bother with socio-economic stuff?" Our commitment as physicians and an association with prevention, care, and rehabilitation demands the contribution of our time, experience, and ability beyond mere patient care. Society expects this contribution as a part of the 100 per cent care we must give our patients. To fail this trust now is to openly invite the government to fill such a void. We must plan for the future: We must get on with plans to redistrict, to improve representation, to improve communication, both to membership and public alike. We must consider ways to involve

the new research-oriented physician in our organization: We must further explore the changing relationship with hospital associations. We must anticipate new and broader coverage by OMI — we are challenged to play our part in the AMA. To make organized medicine creative and responsive, and no longer negatively reactive to change.

In conclusion, I accepted the stewardship of this high office with optimism. I leave it with a sense of humility, but with confidence that the leaders possessing the foresight and devotion required to anticipate and to solve the challenges of tomorrow's medicine are here with us today!

And, Dr. Howard, the "Don't Walk — Run" light is flashing for you at this corner of Ohio and Medicine!

I thank you.

Ohio State Heart Association Elects Officers for Year

Sanford R. Courter, M.D., of Cincinnati, was named president-elect of the Ohio State Heart Association at the annual meeting of the state organization in May. Dr. Courter will succeed George Morrice, Jr., M.D., of Newark, to the presidency in 1968.

Other officers elected at the meeting were: Newton D. Baker, III, of Cleveland, Board chairman to succeed Mrs. Carl A. Strauss of Cincinnati; A. P. Ormond, M.D., of Akron, secretary; Raymond A. Brownsword of Akron, treasurer, and John S. Andrews of Youngstown, assistant treasurer.

Trustees named for the coming year were: Raymond A. Brownsword, A. P. Ormond, M.D., George W. Parry and Mrs. Howard Zehnder of Akron; Jacob F. Hess, Jr., and Richard G. Spitzer, M.D., of Canton; Thomas A. Bittenbender, Sanford R. Courter, M.D., E. Webster Harrison, Samuel Kaplan, M.D., Mrs. Carl A. Strauss and Victor Strauss, M.D., of Cincinnati.

Newton D. Baker, III, George B. Chapman, Jr., Frederick S. Cross, M.D., Ray W. Gifford, Jr., M.D., Richard C. Hollows, Simon Koletsky, M.D., and C. Richard Newpher of Cleveland; Neil C. Andrews, M.D., and Jack S. Silberstein, M.D., of Columbus; Burton G. Must, Sr., M.D., William O. Oswalt and Benjamin Schuster, M.D., of Dayton.

Robert K. Rinderknecht, M.D., of Dover; Walter Oakes of Fairborn; Roger Wise of Fostoria; C. B. Mills of Marysville; Henry Niezgoda of Massillon; Thomas Heisey and George Morrice Jr., M.D., of Newark; D. E. Farling, M.D., of Payne; R. E. Roy, M.D., of Ravenna; Twing Hiscox, of Salem.

Merrit W. Green and J. Lester Kobacker, of Toledo; John S. Andrews, Robert E. Bulkley, William H. Bunn, Jr., M.D., John A. Rogers, M.D., and Angelo Riberi, M.D., of Youngstown.

Annual Meeting Attendance . . .

Figures Show How This Year's Excellent Attendance
Compares with Tabulations on Other Annual Meetings

REGISTRATION FIGURES for the 1967 OSMA Annual Meeting in Columbus, May 15-19, show an excellent attendance, both in number of members, and in the total number of persons present. Overall registration was 3590, with the following breakdown: Members of the Association, 1327; guest physicians, 286; medical students, 394; Woman's Auxiliary, nurses, dentists, technicians, and miscellaneous guests, 1178; scientific and technical exhibitors, 405.

Following are registration figures for members of the Association by counties and a comparison of Annual Meeting attendance figures from 1919 through 1967:

County	Total Membership		Ann. Meet. Registration
	Dec. 31, 1966	May 15, 1967	
Adams	13	10	2
Allen	125	125	22
Ashland	26	26	8
Ashtabula	61	61	3
Athens	37	38	4
Auglaize	16	19	3
Belmont	56	52	6
Brown	15	16	6
Butler	184	178	19
Carroll	10	10	1
Champaign	17	17	1
Clark	130	126	19
Clermont	26	23	2
Clinton	22	19	6
Columbiana	69	71	7
Coshocton	24	23	6
Crawford	40	37	9
Cuyahoga	2322	2227	140
Darke	24	23	5
Defiance	21	22	5
Delaware	27	26	9
Erie	64	63	8
Fairfield	52	50	16
Fayette	16	15	9
Franklin	938	881	360
Fulton	17	16	1
Gallia	35	35	5
Geauga	27	27	2
Greene	54	52	7
Guernsey	26	25	9
Hamilton	1255	1214	108
Hancock	48	46	4
Hardin	26	27	2
Harrison	7	7	2
Henry	16	10	2
Highland	18	16	2
Hocking	8	8	2
Holmes	11	10	4
Huron	27	28	6
Jackson	15	14	6
Jefferson	63	59	11
Knox	39	36	12
Lake	107	104	13
Lawrence	22	22	3
Licking	67	67	19
Logan	15	15	5
Lorain	200	199	20
Lucas	613	570	38
Madison	14	13	6
Mahoning	343	342	19
Marion	66	67	5
Medina	56	54	13
Meigs	6	6	2
Mercer	18	18	2
Miami	66	67	7
Monroe	3	3	
Montgomery	581	549	76
Morgan	3	2	1
Morrow	8	8	3
Muskingum	74	75	15
Noble	2	2	2

Ottawa	24	22	1
Paulding	8	8	2
Perry	9	6	3
Pickaway	19	20	10
Pike	10	9	2
Portage	56	56	10
Preble	9	7	1
Putnam	11	11	2
Richland	118	116	22
Ross	40	39	15
Sandusky	46	47	4
Scioto	67	65	11
Seneca	44	43	5
Shelby	22	24	3
Stark	355	336	21
Summit	570	556	39
Trumbull	132	130	9
Tuscarawas	52	53	12
Union	18	16	6
Van Wert	21	20	5
Vinton	1	1	1
Warren	15	15	3
Washington	31	31	9
Wayne	60	59	9
Williams	18	17	1
Wood	38	38	6
Wyandot	11	11	5
Total	10,096	9,727	1,327

ANNUAL MEETING REGISTRATION FOR 1919-1967 INCLUSIVE

Year	Place	Members	Guest Physicians	Medical Students	Woman's Aux.:		Sc. and Tech. Exhibitors	Total
					Misc. Guests			
1919	Columbus	1173			264	92		1539
1920	Toledo	860			105	80		1062
1921	Columbus	1275			104	96		1503
1922	Cincinnati	1066			184	70		1341
1923	Dayton	1117			202	76		1414
1924	Cleveland	1301			180	109		1603
1925	Columbus	1204			361	107		1689
1926	Toledo	903			120	83		1125
1927	Columbus	1320			286	82		1705
1928	Cincinnati	916			92	80		1115
1929	Cleveland	1231			249	124		1619
1930	Columbus	1241			435	86		1775
1931	Toledo	826			198	50		1087
1932	Dayton	978			201	45		1226
1933	Akron	858			160	25		1049
1934	Columbus	1069			410	51		1539
1935	Cincinnati	973			197	84		1271
1936	Cleveland	1099			563	137		1818
1937	Dayton	1103			366	64		1551
1938	Columbus	1330			619	104		2068
1939	Toledo	1056			271	84		1426
1940	Cincinnati	1126			323	114		1589
1941	Cleveland—Joint Meeting with AMA							
1942	Columbus	1221			527	119		1880
1943	Columbus	544			160			717
1944	Columbus	830			411	130		1421
1945	No Meeting							
1946	Columbus	1262	130	65	507	157		2121
1947	Cleveland	1502	158	15	411	328		2414
1948	Cincinnati	1362	293	27	491	214		2387
1949	Columbus	1533	162	221	462	230		2608
1950	Cleveland	1587	260	102	707	376		3032
1951	Cincinnati	1208	162	185	647	352		2554
1952	Cleveland	1366	204	49	687	395		2701
1953	Cincinnati	1155	180	224	578	298		2435
1954	Columbus	1222	197	173	701	252		2545
1955	Cincinnati	1360	211	185	738	317		2810
1956	Cleveland	1601	338	120	1029	489		3577
1957	Columbus	1164	149	320	689	368		2690
1958	Cincinnati	1327	164	45	674	325		2535
1959	Columbus	1359	293	445	721	364		3182
1960	Cleveland	1642	489	48	1026	447		3652
1961	Cincinnati	1256	231	24	751	301		2563
1962	Columbus	1304	265	343	736	371		3019
1963	Cleveland	1502	336	19	893	441		3191
1964	Columbus	1428	332	297	1002	376		3435
1965	Columbus	1330	275	335	968	394		3302
1966	Cleveland	1484	309	22	865	355		3035
1967	Columbus	1327	286	394	1178	405		3590

Inaugural Address . . .

Incoming President Outlines a Program and Presents a Challenge at OSMA 1967 Annual Meeting in Columbus

By ROBERT E. HOWARD, M. D., Cincinnati

IT GIVES ME a real feeling of humility, to take over the duties of President of the Ohio State Medical Association, when I review the words, actions, ideals, and results of our Ohio State Medical Association leaders during the last five years that I have served on The Council of this Association.

A beloved Past President, the late Dr. George Hamwi, in his 1962 Inaugural Address, quoted from our Constitution, Article 2 — "The purposes of this Association are to promote the science and art of medicine and the protection of the public health; to federate and bring into one compact organization the entire medical profession of the State of Ohio and unite with similar organizations in other states to constitute the American Medical Association." The leader of this organization and another Past President of the Ohio State Medical Association, Dr. Charles Hudson, believes as we do in state leadership and that medicine is only as strong as its grass roots physicians, who are the real providers of the health services to all the people of the United States.

In 1963, Dr. Horatio Pease, another Past President, felt that conflicts in health care would be solved by doing what was best for the patient and for the health of the people of Ohio. I do hope we will continue to follow this philosophy in our doctor-patient relationship.

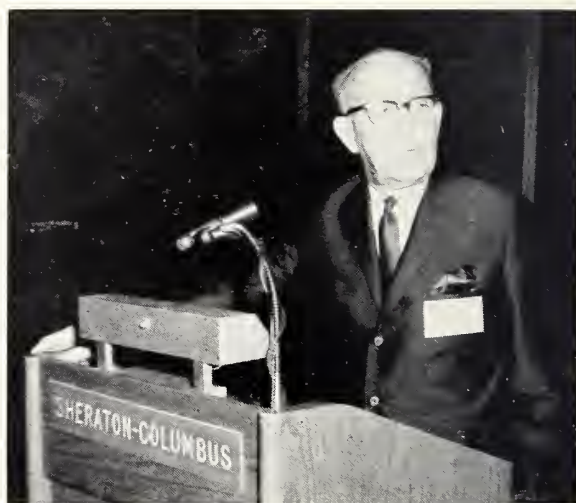
In 1964, still another who has held this office, Dr. Robert Tschantz, challenged the members of our Association to examine the basic political philosophies, new ideas, and concepts before accepting or implementing changes that might deteriorate the health care of our country. He also pointed out the doctor's responsibility in civic service and affairs in the protection of basic human rights.

In 1965, Dr. Henry Crawford alerted us to the problems arising from government legislation already passed and those bills which would interfere with the voluntary way of dealing with mental health, cancer, heart, and stroke.

Dr. Lawrence Meredith, in 1966, urged unity and strength in action against civil rights oath, assignment, certification, recertification, and other rules and regulations of the Department of Health, Education, and

Welfare which would interfere with doctor-patient relationship.

This past year as President-Elect has been a very rewarding one to me in getting acquainted with the district grass roots of our medical organization, committees, The OSMA Council, and the personnel of



Incoming President Robert E. Howard is shown here addressing the House of Delegates.

the Departments of Health and Welfare in our State who are so closely concerned and involved in the new government health care programs.

Cooperation and Understanding

I am hopeful of a closer cooperation and understanding between the Ohio State Medical Association and the Ohio Department of Public Welfare this coming year. There are many pitfalls for the public and the profession in Title XIX, the Medical Assistance Program. With a closer liaison with the Department of Public Welfare, I hope we can make it clear that the average physician is becoming weary of being expected to subsidize the medical part of various welfare programs by furnishing his services at below his usual and customary fees.

Current practices of direct billing to the welfare patient, as a private patient under quality care, has caused a crossfire of criticism from social workers and even officers of the Welfare Department because,

Presented before the House of Delegates during special Inaugural Session on May 16. See Reference Committee report, beginning on page 942.

in previous programs, the doctor was expected to subsidize care on a basis of charity.

Now we are following in our practice of quality care to our welfare patients the statement issued February, 1967, by the U. S. Department of HEW in the "Report to the President on Medical Care Prices," which reads:

"Charity medicine is being abandoned in favor of new public programs which give needy people the resources to purchase medical care from private physicians and hospitals on the same basis as more affluent citizens."

This new look of the Medical Assistance Program under the government Title XIX Medicare law will take time and understanding for a successful outcome.

The Complete Citizen

Unfortunately, as we found out this year, some interpretations of the law in welfare cannot be accomplished in quiet conversation. We cannot let being physicians stand in our way of our becoming complete citizens. We must become more active politically.

If Medicare is something that we have to endure, then amendments must be considered and properly executed by men we choose to elect and send to Congress, where laws emanate. It is true that we must attempt to control the drastic expansion of Medicare, if quality health care is to survive in this country.

The Ohio Department of Health is concerned in Medicare with certification of providers, such as hospitals, extended care facilities, home health care agencies and independent laboratories and to assist in developing such resources to the community, commensurate with need. The Department is also to develop sound coordination between Medicare and health programs, both current and future. By future, we must be most concerned with Public Law 89-749, the Comprehensive Health Planning and Public Health Service Amendments of 1966.

The Ohio State Medical Association must show very active participation on the State Health Planning and Service Council, since there is a lack of definition in the scope of health services in this expanded grant program.

I feel that our newly formed OSMA Government Medical Care Programs Committee and its subcommittees are keeping us alerted to changes in rules and regulations of the HEW Department, so that we can make objections before they become law. We must publicize the truth in whatever medium is available to refute the planned propaganda coming out of Washington. For example: The President orders an investigation of the increases in health costs, and Wilbur Cohen nationally claims that 300,000 doctors were paid by Medicare in the first six months. Social Security

Commissioner Robert M. Ball calls the program a smooth voyage for the hospitals. The Medicare impact on the nation's hospitals was where it hurts — in the purser's office — not in the sick bay.

We need a change in the thinking and future planning of the American Hospital Association which, with Blue Cross, actively supported Medicare.

Already, the President is worried about the cost of the votes he has bought through Medicare, since his purchase means more and more taxes.

I need not continue, for you are all acquainted with the facts, but your patients and congressmen should know the truths.

Let us give our best in medical care to our patients. Let us back our local county, state, and national organizations, even if we do not agree with all their actions. If you are not active in your grass roots organization, how can your officers know your thoughts on involved legislation?

In closing, I pledge my efforts to keep the Ohio State Medical Association at the top, with the combined help of The Council, Officers, Delegates, Committeemen, and the physicians representing the grass roots of our Association.

Thank you.

VA Patients Like Hospiatl Care, Congressional Poll Shows

A Congressional poll of former patients in Veterans Administration hospitals shows 97.7 percent responded favorably to questions about how they liked the personal care, service, food, etc.

The second annual quiz of VA veteran-patients was directed by Rep. Olin E. Teague (D-Tex.), chairman of the House Veterans Affairs Committee, who told Congress:

More than 7,000 former patients of 122 VA general medical hospitals responded to the questionnaire sent by Congressman Teague, whose staff compiled the statistics presented to Congress.

Out of a possible 100 percent, some of the results were:

Question	Yes
Did the admitting doctor interview you in a friendly and understanding manner?	96.6
Was your room attractive, clean, well ventilated, well lighted, and bed comfortable?	96.6
Were you annoyed by so-called hospital odors?	4.0
Were you awakened too early in the morning?	11.7
Were you satisfied with visiting hours, treatment of visitors?	97.8
Did you have as much nursing care as you needed?	97.0
Did the doctors give you friendly, efficient service?	96.4
Was a good room cleaning job done?	96.5
Were the meals adequate?	96.6
Was the "hot" food served hot?	90.5
Did you like the coffee?	88.0
In general did you receive good hospital care?	97.7

Annual Meeting in Review...

Highlights and Sidelights on People, Happenings, and Events that Spells Out Another Annual Meeting Success

WHAT is the OSMA Annual Meeting? It is more than 2000 physicians and future physicians gathered in one place, to take refresher courses and to exchange ideas with their colleagues. It is more than 150 speakers, panelists, and demonstrators taking part in various phases of the program. It is some 170 members of the House of Delegates, plus Alternate Delegates, meeting to establish the Association's policy. It is exhibits, dinners, luncheon, social events, of numerous medical groups. It is Ohio Medicine in action.

Elsewhere in this issue are official proceedings of the House of Delegates, presentation of newly elected Officers and Councilors, the President's Address, Inaugural Address of the Incoming President, record of attendance, report from the Woman's Auxiliary, etc.

Following are a few miscellaneous items on important events of the Annual Meeting, together with some sidelights that attempt to reflect the spirit as well as the substance of the week's events. Photographs distributed throughout these reports give additional insight into happenings.

Official Hosts

Dr. Tom F. Lewis, Columbus, as president of the host Academy of Medicine of Columbus and Frank-

lin County, officially opened the House of Delegates meetings and welcomed members and guests to Columbus.

Contributing greatly to the success of the meeting were numerous members of local committees, as well as members of the Woman's Auxiliary who served on local committees. Many of the special events, for example, luncheons and dinners of specialty societies, were hosted by local committees.

OMPAC-AMPAC Luncheon

Another successful event that drew a great deal of interest was the luncheon sponsored by the Ohio Medical Political Action Committee and the American Medical Political Action Committee.

Special speaker for the occasion was the Hon. John M. Ashbrook, Johnstown, Congressman of the Seventeenth Ohio District, who discussed "The Role of the Physician in Politics." Elsewhere in the issue is an article on OMPAC and its campaign to recruit more members—especially in view of the coming all-important campaign year 1968.

AMA-ERF

Checks representing proportionate parts of the funds raised by the American Medical Association Education and Research Foundation were presented



The Gas Light Party on Thursday evening was a gala event enjoyed by some 600 members and guests. Added attraction was a song fest by the Navigators, Naval Aviation Glee Club from the Pensacola, Florida base.



An innovation at this year's Annual Meeting was a series of Closed Circuit Color TV Programs originating at Ohio State University Medical Center and viewed at the Veterans Memorial Building as well as at the hospital. The Wednesday morning panel consisted of Dr. John E. Jesseph, Moderator, Dr. Charles L. Cogbill, Dr. Robert E. Hermann, and Dr. Stuart S. Roberts. Speaking from the point of origin were Dr. William G. Pace, and Dr. Robert M. Zollinger. Presentations were arranged through the courtesy of Smith Kline & French Laboratories.



A panel discussion sponsored by the Ohio Division of the American Cancer Society included Dr. Michael R. Deddish, Dr. John R. Hill, Dr. Victor A. Gilbertsen, Dr. Rupert B. Turnbull, and Dr. Murray S. Jeffe. Dr. Joseph A. Bonta, (not shown) was also a member of the panel.



C. Joseph Stetter, Washington, President of the Pharmaceutical Manufacturers Association, is shown at the rostrum presenting part of the panel discussion on "Drug Regulations and Compulsory Generic Prescribing." Seated, left, is Dr. Max S. Sadore, Chicago, second panelist, and Dr. Perry R. Ayres, Columbus, Editor of THE JOURNAL, who presided.

to medical schools in Ohio. Dr. Robert S. Martin, Zanesville, Ohio AMA-ERF chairman, presented checks at the House of Delegates session to Dr. Frederick T. Suppes, Western Reserve University School of Medicine; Dr. Clifford G. Grulee, Jr., University of Cincinnati College of Medicine; and Dr. Richard L. Meiling, Ohio State University College of Medicine.

Humanitarian Service

Impressive ceremonies before the House of Delegates were those in which certificates of humanitarian service were presented to nine Ohioans who had served as civilian physicians in South Vietnam under the Volunteers for Vietnam project sponsored by the American Medical Association.

President Lawrence C. Meredith presented certificates to the following persons: Dr. Robert E. Cooke, Harrison; Dr. James Q. Dorgan, Jr., Columbus; Dr. Mark T. Hoekenga, Cincinnati; Dr. Anthony C. Nassif, Cleveland; Dr. James B. Patterson, Lorain; Dr. Robert E. Sooy, Mt. Vernon.

Not present were the following persons who received their certificates later: Dr. Joseph H. Gaudreault, Hickley; Dr. Jerry C. Rosenberg, Toledo; and Dr. Rainer S. Pakusch, formerly of Maumee, but now of Dearborn, Mich.

Past Presidents of OSMA Honored

The traditional dinner of The Council, honoring Past Presidents of the Association, was held on Tuesday evening of the Annual Meeting week in the Sheraton-Columbus Hotel. Elsewhere in this issue is a photograph of Past Presidents present for the occasion.

News Media Coverage

When more than 2000 physicians and medical students meet in Annual Session, that's news. News media coverage of the Annual Meeting was excellent, by press, television, and radio. News media coverage applied to pre-meeting announcements as well as reports during and after the meeting.

Committees Named

Numerous committees, both scientific and organizational, perform important functions within the Ohio State Medical Association. Some of these committees are named by the President with the approval of the House of Delegates, and others by the President with the approval of The Council. The new roster of committees is printed in the back of this issue, beginning on page 991.

Honored Guests

In addition to the out-of-state guest speakers on the program, the Association was honored with dignitaries from neighboring states. Among them were Dr. Eugene S. Rifner, Van Buren, Indiana, president of the Indiana State Medical Association; Dr. Richard E. Flood, Weirton, West Virginia, president of the



President Lawrence C. Meredith strikes a serious pose at a festive occasion, the dinner meeting of The Council honoring Past Presidents of the Association.



This panel drew a large audience to the main Auditorium of the Veterans Memorial Building. The topic, "Educating Patients About Sexual Relationships," was presented by Dr. Mary S. Calderone, of New York City; left; Dr. Alan F. Guttmacher, also of New York; and Dr. Margaret J. Schneider, Cincinnati.



Featured Speaker for the luncheon meeting of the Ohio Medical Political Action Committee, was the Hon. John M. Ashbrook, Johnstown, Congressman of the Seventeenth Ohio District, shown here at the rostrum.

West Virginia State Medical Association; Dr. James S. Klumpp, Huntington, Past President of the West Virginia State Medical Association; Dr. George F. Brockman, Greenville, Kentucky, President-Elect of the Kentucky Medical Association; and Dr. K. M. Kressenberg, Pulaski, Tennessee, President of the Tennessee Medical Association.

Another honored guest was Dr. Milford O. Rouse, Dallas, Texas, then President-Elect of the American Medical Association. Dr. Rouse spoke at a general session, using as his topic, "Current Problems Facing American Medicine."

For names of additional guests, see report of the Woman's Auxiliary Annual Meeting, elsewhere in this issue.

Gaslight Party

An innovation of this year's Annual Meeting was the Gaslight Party on Thursday evening in the spacious ballroom of the Neil House. This gay event proved to be very popular with members and guests.

Entertainment was provided by the Gaslight Road Show, direct from Chicago's Gaslight Club; plus the Keystone Brothers, the Al Myers Quartet, and other features. Snack bars, liquid refreshments served the old fashioned way, dancing and costumes of Roaring 'Twenties vintage all added up to a full evening of entertainment.

Montgomery Glee Club

Another innovation of the meeting was a special Inaugural Session of the House of Delegates on Tuesday afternoon. Entertainment for that occasion was provided by the Montgomery County Medical Society Glee Club, directed by Dr. William J. Lewis, Jr., of Dayton.

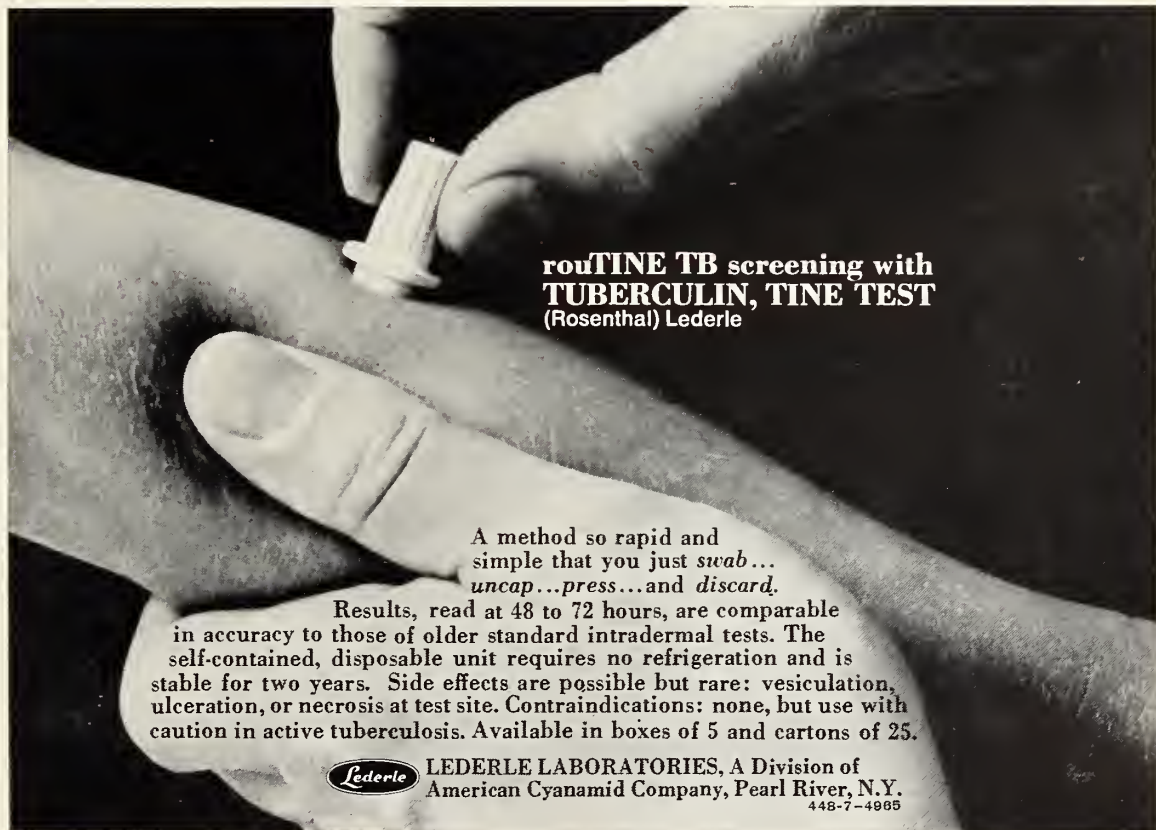
Heart Research Applications Date Is September 15

Applications from research investigators for support of studies to be conducted during the fiscal year beginning July 1, 1968, now are being accepted by the American Heart Association, according to information released by the Ohio State Heart Association.

September 15, 1967 is the deadline for submitting applications for Established Investigatorships, Advanced Research Fellowships, Visiting Scientists and British-American Research Fellowships.

Applications for Grants-in-Aid should be submitted by November 1, 1967. Grants-in-Aid are made to experienced investigators to help underwrite the costs of specified projects, such as equipment, technical assistance and supplies.


Application forms for research awards may be obtained from the Director of Research, American Heart Association, 44 East 23rd Street, New York, N.Y. 10010.



**rouTINE TB screening with
TUBERCULIN, TINE TEST**
(Rosenthal) Lederle

A method so rapid and
simple that you just *swab...
uncap...press...and discard.*

Results, read at 48 to 72 hours, are comparable
in accuracy to those of older standard intradermal tests. The
self-contained, disposable unit requires no refrigeration and is
stable for two years. Side effects are possible but rare: vesiculation,
ulceration, or necrosis at test site. Contraindications: none, but use with
caution in active tuberculosis. Available in boxes of 5 and cartons of 25.

 **LEDERLE LABORATORIES**, A Division of
American Cyanamid Company, Pearl River, N.Y.
448-7-4985

Dr. Annis last month—quite an undertaking for a county auxiliary of 65 members. The women in Licking County and that part of the state enthusiastically supported Rep. Ashbrook, our luncheon speaker today.

Funds have been raised for AMA-ERF—some \$38,000 last year in Ohio—\$345,000 nationally. We rated second only to California. The ingenuity of our doctors' wives shows here quite vividly in the wide variety of fund-raising ideas. We hope to raise \$40,000 this year. If each member would use just ONE "In Memoriam", "In appreciation" or in "In Honor of" card (all of which is tax deductible), how easy this would be.

Recruiting of personnel for the many areas of the Health Careers field has been done by most counties in one way or another. They have supplied some \$35,000 in scholarships and loan, sponsored some 50 Future Nurses and Physicians Clubs, held Health Careers Days, sponsored Health Careers exhibits at County Fairs. Several counties published booklets giving all the facts concerning Health Careers in their areas—schools, cost, available scholarships, etc. Programs were varied this year and showed the interest of the groups has been oriented toward learning more about the health problems in their communities. Several counties are assisting in solving problems of schooling of the retarded, helping in sheltered workshops, or raising funds for both schools and workshops.

Volunteer services included all types of help in hospitals through membership in their local hospital guilds and auxiliaries, teaching first aid courses, sitter courses (for care of both young and old), assisting the Medical Societies in disaster drills, staffing of blood banks, serving on speakers' bureaus for cancer, mental health, and safety, also making surveys for their medical societies.

The unwed mother, early marriage with high rate of divorce, the drop-out, the alarming increase in incidence of venereal diseases, plus the problems of welfare have made us aware of the need for Family Life Education programs in our schools. Several counties have had meetings inviting school superintendents, PTA and PTU, YWCA, Girl Scout leaders and others who concern themselves with our youth to hear excellent panels of doctors, social workers and the church come together to discuss the problem. The family is the keystone of our society. How can we bolster the moral tone in this particular field?

Members in Erie County assisted their Medical Society in a Measles Vaccine Clinic where 1,500 children were inoculated in three hours. They also do hearing testing in grades 2, 5, 8—testing some 1,402 children. They trained their own testers.

The larger Auxiliaries have many interest groups—bowling, knitting, book review, ceramics, painting, gourmet cooking, french beading, to name a few—where wives can get to know one another better and

learn new skills. We have a Hobby Show at the Neil House, at this Convention, with many interesting exhibits. Ruth Meltzer, our newest author, has her first novel on sale at our headquarters in the Neil House. *Falls the Shadow* involves the story of radiology. Forty per cent of the sales price at the convention will go to AMA-ERF.

In the international health field, foreign doctors and families have been made to feel welcome, tons of medical samples not being used have been sent overseas, scholarships provided for ancillary help to doctors in Vietnam, knitting of leper bandages, sending of sheets to be used as bandages and hospital coats, and interesting other groups to help in this worthwhile project.

Friendly visitors to the aged and "Meals on Wheels" programs have been explained to groups and put into service in areas of the state.

Awareness of the needs for legislation in the fields of highway safety, air and water pollution, and the welfare programs of our State is evident.

We raised the dues last year and now have a Central Office here in Columbus where we can store all the records, archives, reports, and memorabilia that heretofore has been in Board Members' attics, basements, spare bedrooms, and garages. We plan an "Open House" at the new office for Wednesday evening 8:00 to 10:00 o'clock. We have rented the lower level of the Ohio Academy of General Practice Building at 4075 North High. We invite you to attend.

Our magazine, published four times a year, has won kudos from the National Association and is the envy of many State Auxiliaries.

We worked with two WA-SAMA groups and have a third in the making. I attended their 10th Anniversary Convention last week and was most impressed with the dedication, know-how, and good common sense, shown. They (medical students' wives) are our future members. Our young folks everywhere are doing a good job in most areas. They have received a very poor press—the few who are questionable get all the headlines.

We are your partners in marriage and most willing to become knowledgeable in the many areas of your concern. We thank you for inviting us to join you in this meeting and for sharing your speakers with us. We also thank you for the financial assistance you have given us and for your interest in all our endeavor.

Radiation therapy facilities of the University of Cincinnati Medical Center will be augmented by a new Cobalt-60 teletherapy unit at the Christian R. Holmes Hospital, made possible by an anonymous donation and a \$25,000 gift from the Union Central Life Insurance Company.

Teenage Athletics...

Fourth Postgraduate Institute for Physicians Scheduled In Columbus, for August 16-17, Under Joint Sponsorship

THE Fourth Postgraduate Institute for Physicians on Medical Aspects of Teenage Athletics will be held at the Fort Hayes Hotel in Columbus on Wednesday and Thursday, August 16-17, 1967. This program is jointly sponsored by the Ohio State Medical Association, the Ohio High School Athletic Association, and the Ohio State University College of Medicine.

This program designed expressly for physicians, is planned to provide the team physician with current concepts involved in the prevention and care of athletic injuries.

Previous Institutes conducted in 1960, 1962, and 1964 were extremely popular. Many physicians wanting to attend one of these past meetings could not because of limited enrollments. This year there will be facilities for only 125 registrants. If you plan to attend you should send your application in early.

Application should be made on the accompanying coupon and directed to the Ohio State Medical Association, not later than August 14. Registration fee of \$25.00 includes costs of two luncheons and a social hour.

Registration opens at 9:00 A.M. on Wednesday, August 16, on the second floor of the Fort Hayes Hotel, 30 W. Spring St., Columbus.

A block of sleeping rooms has been set aside for participants of this Institute. Room reservations should be made directly with the hotel.

Program events will be in the Fort Hayes Hotel, except for Thursday afternoon. The program is as follows:

Wednesday Morning—August 16

Registration opens 9:00 A.M.

Presiding—Paul E. Landis, Commissioner, Ohio High School Athletic Association.

Safeguarding Athletes in Ohio High Schools—
Harold A. Meyer, Asst. Commissioner, OHSAA.

Proceedings of the Medical Aspects of Sports Committee: American Medical Association—
Thomas E. Shaffer, M. D., Columbus.

The Physician-Coach Relationship—
Robert E. Reiheld, M.D., Team Physician, Orville.
William Shunkweiler, Coach, Warren High School

"The Pinched Nerve"
Anatomical Considerations—
Jack N. Meagher, M. D., Columbus.

Management—
Richard Patton, M. D., Columbus.

Prevention—
Ernest R. Biggs, Head Trainer, OSU.
Noon Luncheon

REGISTRATION: Postgraduate Institute on Medical Aspects of Teenage Athletics

NAMEM.D.

ADDRESS

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APPLICATIONS MUST BE RECEIVED
BY AUGUST 14

Make checks payable and
Mail to: Herbert E. Gillen, Institute Treasurer
Ohio State Medical Association
17 S. High St., Columbus, Ohio 43215

Fee Enclosed
(\$25) includes
2 Luncheons and the
Reception at
Ohio Stater Inn
EXTRA
Reception tickets \$3.00
Total Enclosed

Wednesday Afternoon—August 16

Presiding—Sol Maggied, M.D., West Jefferson.

Booth Seminars—

Group 1—Contact Lenses—

R. H. Magnuson, M. D., Columbus, and
Joseph Bitonte, B. E. E., Columbus.

Group 2—Prevention of Heat Illness—

Robert J. Murphy, M. D., Columbus.

Group 3—Traumatic Abdominal Injuries—

Luther M. Keith, M. D., Columbus.

Group 4—Technique of Injection—

Judson D. Wilson, M. D., Columbus.

Group 5—Dental Protection—

William D. Heintz, D.D.S., Columbus.

Ideal Equipment for a High School Training Room—

Ernest R. Biggs

Symposium on the Knee—

Anatomy of Interest; Dangers of Intra-articular Injection

Richard M. Ward, M. D., Columbus.

Common Football Knee Injuries; Indication for Surgery

Mel L. Olix, M. D., Columbus.

Evening Social Hour

Thursday Morning—August 17

Presiding—Walter A. Hoyt, Jr., M.D., Akron.

The Athlete with an Orthopedic Handicap—

Walter A. Hoyt, Jr., M.D.

America's Fastest Growing High School Sport—Wrestling

Rules on Weight Classes—Ohio and Nationwide—

College and High School—

Casey Frederick, OSU Wrestling Coach.

Medical Viewpoint on Weight Loss—

George Owen, M. D.

Adolescence and Wrestling—

Thomas E. Shaffer, M. D.

Quackery in Rx of Athletic Injuries—

Kenneth S. Clarke, Ph.D., American Medical Association.

Treatment Nuggets in Management of Athletic Injuries—

John R. Jones, M.D., Toledo.

Marvin R. McClellan, M.D., Cincinnati.

Sanford Press, M.D., Steubenville.

Noon Luncheon

Thursday Afternoon—August 17

St. John Arena—OSU Campus

Presiding—Robert J. Murphy, M.D.

Latest Techniques in a Physical Training Program—

Glenn Swengros, Executive Secretary.
President's Council on Physical Fitness
Washington, D.C.

Demonstration-Techniques—

Students from Ohio State University, directed by
Mr. Swengros.

"FOOTBALL 1967"—

W. W. Hayes
Head Football Coach
Ohio State University

Adjournment at 4:00 P.M.

WHAT TO WRITE FOR

False Neurochemical Transmitters—Reprint of the proceedings of a Combined Clinical Staff Conference held at the National Institutes of Health, and published in *Annals of Internal Medicine*. Address request to Clinical Center Information Office, National Institutes of Health, Room 1-N-248, Building 10, Bethesda, Md. 20014.

* * *

Eye Research—A 44-page illustrated pamphlet written for the general reader reviews the known causes and current treatment for more than 20 blinding disorders as well as the latest research findings. Prepared by the National Institute of Neurological Diseases and Blindness, it is listed as Public Health Service Publication No. 1502. For sale by the Superintendent of Documents, U. S. Printing Office, Washington, D. C. 20402; 35 cents per copy.

* * *

Drug Abuse: Escape to Nowhere; Designated as "A Guide for Educators," this pamphlet is objective and factual. It was reviewed by a panel of educators, physicians, pharmacists, and law enforcement officers, and is recommended for any one who works with young people. Published by Smith Kline & French, pharmaceutical manufacturing firm, the booklet is available at \$2.00 a copy from the American Association for Health, Physical Education, and Recreation, 1201 Sixteenth Street, N. W., Washington, D. C. 20036.

	Membership	
	OSMA Dec. 31, 1966	OMPAC June 6
Tenth District		
Delaware	27	12
Fayette	16	14
Franklin	928	415
Knox	36	20
Madison	14	4
Morrow	8	5
Pickaway	17	10
Ross	39	21
Union	18	2
	1103	503
Eleventh District		
Ashland	25	11
Erie	67	9
Holmes	10	5
Huron	28	12
Lorain	193	47
Medina	57	14
Richland	119	43
Wayne	60	29
	559	170
TOTALS	10,042	2,617

Novel Inspired by Ohio Doctor Packs Unique Medical Punch

Falls the Shadow—A novel by Ruth K. Meltzer; published by Vantage Press, New York City; listed at \$5.95. Obtainable also at bookstores.

The author of this novel needs no introduction to *The Journal's* readers. She is the widow of an Ohio physician, an active member of the Woman's Auxiliary, and in recent years, under her by-line, the Auxiliary Highlights column has taken on new dimensions in communication.

The novel was appropriately introduced at the recent OSMA and Auxiliary Annual Meetings in Columbus. It is the story of a physician—a free agent in his professional practice; a man dogged by a shadow in his personal and family life.

Of marked significance is the Foreward, written by Benjamin Felson, M.D., of Cincinnati, who writes in part: ". . . This foreword provides me the opportunity to support my beloved specialty. *Falls the Shadow* calls the public's attention to the high place which radiology holds in the healing arts and promotes understanding by those who need, yet fear, its ministrations.

"Apart from its story, the book has many additional facets which, as with a gem, enhance its worth. The professional in medicine, preoccupied with the scientific or technical aspects of his work and more or less inured to suffering, seldom appreciates fully the emotional impact of what he finds or does. The layman, on the contrary, is rarely provided the opportunity to view untheatrically the happenings backstage. Both aspects of this coin are clearly yet honestly treated by the author, who has in part lived her story . . ."

The author has indeed in part lived her story. The central figure in the novel is Dr. Dean Carpenter, radiologist who practices in a small mid-western city, and whose experiences in some other respects parallel those of the author's late husband, Dr. Samuel L. Meltzer. Skillfully woven into the theme of the story is the drama of radiology, and an intimate look at some of its gallant pioneers. But, as the reader will find, this is no documentary presentation. The author calls upon a vivid imagination to weave a moving and meaningful drama around deftly-drawn characters.

She lays the foundation for her story deep in the childhood of her leading character, a less than ideal climate for a sensitive youngster. The boy's determination to become a radiologist stems from youthful admiration for a beloved physician, and curiosity about the rays and shadows that helped him diagnose disease and treat patients. From still deeper in his childhood falls the shadow of a woman bereft of mother love, a shadow from which he can never fully extricate himself.

Drama reaches its climax when doctor becomes patient, and doctor-patient struggles against the seeming insurmountable odds of an existence without voice to communicate. In this episode, man and medicine reach a sublime triumph.

As the Foreword writer points out, probably radiology has never before been the basis of a novel nor has the laryngectomy been dramatized in fiction. This book indeed "packs a unique medical punch."

Opinion on Coroner Taking of Blood Specimens from Accident Victims

Following is the syllabus of an opinion given recently by Attorney General William B. Saxbe.

"There is no authority in the law for the coroner, by request of law enforcement officials or otherwise, to take the blood from a deceased driver victim of an automobile accident for the purpose of compiling data for a study of the relationship between driving under the influence of alcohol and fatal automobile accidents." —Opinion of the Attorney General No. 67-024.

Dr. Trent W. Smith, Columbus, was named a member of the board of directors of the American Academy of Facial Plastic and Reconstructive Surgery at the organization's recent meeting in Montreal, Canada. He is a past president of the organization. He is associate clinical professor of otolaryngology at Ohio State University, and chief of the Department of Otolaryngology in Children's Hospital, Columbus.

Ad Astra

Harold A. Budd, M. D., Aurora; Western Reserve University School of Medicine, 1909; aged 83; died May 16; member of the Ohio State Medical Association. Formerly in private practice in Cleveland, Dr. Budd became assistant superintendent of the Massillon State Hospital in 1947 and in 1952 was named superintendent of the Cleveland State Hospital. He was a veteran of World War I, during which he served in the Army Medical Corps. Survivors include his widow and a sister.

Frank H. Clark, M. D., Cleveland; Wayne State University College of Medicine, 1928; aged 67; died May 5; member of the Ohio State Medical Association, the American Medical Association, and the American Academy of General Practice. A practitioner of long standing in Cleveland, Dr. Clark was chief of the physical medicine and rehabilitation service at Doctors Hospital. He was an active sponsor of the Hillcrest Hospital to be built in Mayfield Heights. A veteran of the Army Medical Corps in World War II, he was active in a number of Masonic bodies and was head of the Al Koran Medical Corps. Surviving are his widow, a grandson, and a stepson.

Dana Wesley Cox, M. D., Columbus; Western Reserve University School of Medicine, 1928; aged 69; died May 31; member of the Ohio State Medical Association and the American Medical Association; diplomate of the American Board of Obstetrics and Gynecology. A practitioner of long standing in Columbus, Dr. Cox was clinical professor of obstetrics and gynecology at Ohio State University College of Medicine. He is survived by his widow, three sons, a daughter, and three stepchildren; also a sister.

Horace Asa Day, M. D., Orlando, Florida; University of Cincinnati College of Medicine, 1923; aged 72; died February 20. Records indicate that Dr. Day moved to Florida shortly after receiving his medical degree in Ohio.

Rosendo Forteza, Jr., M. D., Alhambra, Calif.; Ohio State University College of Medicine, 1939; aged 60; died January 13; former member of the Ohio State Medical Association. Dr. Forteza practiced for a short time in Cincinnati before moving to California.

Huston Fenn Fulton, M. D., Columbus; Ohio State University College of Medicine, 1925; aged 67; died May 31; member of the Ohio State Medi-

cal Association, the American Medical Association, American Roentgen Ray Society, Radiological Society of North America; Fellow of the American College of Radiology; diplomate of the American Board of Radiology. A practitioner of long standing in Columbus, Dr. Fulton specialized in radiology. He was active in numerous community affairs; was a member of the Rotary Club, Chamber of Commerce, and the First Community Church. Survivors include his widow and two daughters.

John A. Gammel, M. D., Cleveland; Julius-Maximilian University Faculty of Medicine, 1922; aged 72; died May 17; member of the Ohio State Medical Association, the American Medical Association, and the American Dermatological Association; diplomate of the American Board of Dermatology. A practicing dermatologist of long standing in Cleveland, Dr. Gammel was on the faculty of Western Reserve University School of Medicine from 1924 to 1958. He was a past president of the Cleveland Dermatological Society; a member of the Catholic Church, and of the Knights of Columbus. Surviving are his widow, two sons, a daughter, and a sister.

Frederick Lyle Gray, M. D., Long Beach, Calif.; University of Cincinnati College of Medicine, 1952; aged 49; died May 3. A diplomate of the American College of Obstetrics and Gynecology, Dr. Gray specialized in that field in the Long Beach area. Surviving are his widow, two sons, two daughters, his parents, and three sisters.

Alexander F. Haas, M. D., Bainbridge; Ohio State University College of Medicine, 1909; aged 85; died April 30; member of the Ohio State Medical Association and the American Medical Association. A native of Ross County, Dr. Haas devoted his entire professional career to practice in that area. His office was at Boumeville until 1929 when he moved to Bainbridge, both communities in the southwestern part of the county. Among affiliations, he was a member of the Methodist Church and the Odd Fellows Lodge. Survivors include his widow, a daughter, a son, and two sisters.

Charles H. Hamilton, M. D., Lancaster; Ohio State University College of Medicine, 1908; aged 83; died May 22; member of the Ohio State Medical Association and the American Medical Association. Except for a short period at the beginning of his practice, Dr. Hamilton served virtually all of his professional

career in the Lancaster area. He was a veteran of World War I, having served overseas with the 37th Division. Affiliations included memberships in the American Legion, several Masonic bodies, and the Methodist Church. Surviving are his widow, and a daughter.

Zan Edward Jones, M.D., Sunnyvale, Calif.; Western Reserve University School of Medicine, 1963; aged 35; died February 23 as the result of a traffic accident. Dr. Jones was associated with the Lockheed Missiles and Space Company in California.

Charles Everett Lemmon, M.D., Grosse Pointe, Mich.; Western Reserve University School of Medicine, 1916; aged 77; died January 28. Records indicate that Dr. Lemmon practiced for many years in the Detroit area.

Amos L. Lynch, M.D., Columbus; Meharry Medical College, 1925; aged 81; died on or about April 28. Dr. Lynch practiced medicine for some 40 years in Columbus. He is survived by his widow, a daughter, two brothers, and a sister.

Walter F. Pretorius, M.D., Fort Recovery; Ohio State University College of Medicine, 1956; aged 36; died May 4; former member of the Ohio State Medical Association and recently a member of the Indiana State Medical Association; member of the American Medical Association, and the American Academy of General Practice. Dr. Pretorius opened his practice at Fort Recovery in 1963 and recently had started a special clinic for diagnosis and treatment of children. He is survived by his widow, six children, his parents, a sister, and a brother.

Phillip Irving Rossman, M.D., Corte Madera, Calif.; Western Reserve University School of Medicine, 1961; aged 31; died January 26 of accidental multiple injuries. Dr. Rossman was affiliated with the Letterman General Hospital in San Francisco.

George J. Salisbury, M.D., Cleveland; Cleveland-Pulte Medical College, 1906; aged 88; died May 27; former member of the Ohio State Medical Association and the American Medical Association. Dr. Salisbury retired about a year ago after practicing in Greater Cleveland for 60 years. Two daughters and a brother survive.

Homer A. Sutter, M.D., Largo, Florida; Eclectic Medical College, Cincinnati, 1911; aged 80; died May 11. Dr. Sutter practiced for some 54 years in Cincinnati before he retired and moved to Florida. He is survived by a son, a daughter, and two sisters.

Raymond E. Wehr, M.D., Hamilton; University of Cincinnati College of Medicine, 1932; aged 59; died May 10; member of the Ohio State Medical Association and the American Medical Association. A specialist in public health service work, Dr. Wehr had been Hamilton health commissioner since March

1966. For many years he served as health commissioner in Kentucky, and from 1948 to 1960 was associated with the Cincinnati Health Department. Prior to accepting the Hamilton appointment, he was director of medical facilities (Hill-Burton) for the Ohio Department of Health. His widow and a son survive.

Andre A. Weil, M.D., Cleveland; Faculty of Medicine, University of Bern, 1938; aged 55; died May 8; member of the Ohio State Medical Association, the American Medical Association, American Academy of Neurology, American Psychiatric Association, and Central Neuropsychiatric Association; diplomate of the American Board of Psychiatry and Neurology. Dr. Weil's practice in Cleveland began in 1945 and was limited to the field of neuropsychiatry. Educated in Europe, he came to this country in 1939 and practiced in the East before moving to Ohio. His widow survives.

Vogt G. Wolfe, M.D., Urbana; Starling Medical College, 1905; aged 88; died May 17; member of the Ohio State Medical Association and the American Medical Association. A native of Fletcher, in neighboring Miami County, Dr. Wolfe served virtually all of his professional career in the Urbana vicinity. He was a member of the Masonic Lodge and the Methodist Church. Surviving are his widow, a daughter, and two sisters.

Ohioan Named to National Board Executive Committee

Dr. Frederick T. Merchant, Marion, a member of the State Medical Board of Ohio, recently was named to the Executive Committee of the National Board of Medical Examiners, a voluntary agency whose qualifying examinations are recognized by most of the state medical boards.

Dr. Merchant's service on the Executive Committee is in addition to his membership on the board itself. As a member of the Federation of the State Medical Boards of the United States, he was elected about two years ago as a representative of the Federation to the National Board. Under the constitution and bylaws, five members of the Board are nominated by the Federation.

Dr. Merchant also is a member of the Executive Committee of the Federation, and a member of its Examination Institute Committee, a group whose interests and activities are closely allied with the National Board in matters of licensure and examination.

Dr. Merchant is now serving his second seven-year term on the State Medical Board of Ohio under the Governor's appointment. He is a member of The Council of the Ohio State Medical Association, as Councilor of the Third District.

Activities of County Societies...

BELMONT

The Belmont County Medical Society, with the Auxiliary, met at the Belmont Hills Country Club on June 15. A late afternoon program preceding dinner featured Dr. Robert N. Lewis, St. Clairsville, whose topic of discussion was, "Malaria in the Returning Vietnam Veteran."

BUTLER

The Butler County Medical Society recently held a postgraduate medical seminar followed by a dinner dance at the Hamilton Elks Club. A team of five members of the staff of the University of Kentucky Medical College conducted the afternoon seminar.

CUYAHOGA

Dr. Elden C. Weckesser recently was installed as president of the Academy of Medicine of Cleveland and Cuyahoga County Medical Society, succeeding Dr. David Fishman.

Dr. John J. Grady was named president-elect, and Dr. Leo Walzer, vice-president. Dr. Fred R. Kelly was re-elected secretary-treasurer.

The official publication of the Academy of Medicine of Cleveland and Cuyahoga County Medical Society was published with a new cover design and format as of the June issue, and under the title *Cleveland Physician*. The editorial staff announced: "This is also the first *Bulletin* printed in our own *Print Shop*."

The Cleveland Society of Internal Medicine in cooperation with the Academy will sponsor a series of panel discussions beginning September 6 under the general topic, "Non-Academic Facets of the Practice of Medicine."

HAMILTON

Members of the Academy of Medicine of Cincinnati attended the annual President's Ball on May 20 at the Academy building. A social hour was followed by dinner and a short meeting, after which the evening was devoted to dancing.

The election results were announced as follows: Dr. W. R. Culbertson was named president-elect to assume that office in September and to be installed as president in September 1968.

Dr. Stanley D. Simon is the current president-elect and will be installed as president at the annual meeting in September, to succeed Dr. Elmer R. Maurer. Others elected include Dr. Stephen P. Hogg, secretary; Dr. Samuel P. Todd, Jr., treasurer; Dr. Harry K. Hines, trustee, and Dr. Robert S. Heidt, councilman-at-large.

LORAIN

James B. Patterson, M.D., a member of Lorain County Medical Society, presented a program on "Project Vietnam" at the regular meeting of the Society on May 9th. Dr. Patterson was the first Lorain area physician to volunteer for duty under the AMA Volunteers for Vietnam program, and with slide presentations he brought first hand knowledge of the health situation in Vietnam to the membership.

On Sunday, May 21st, Lorain County Medical Society also sponsored an "End Measles" Campaign in co-operation with the State of Ohio Department of Health. Moving into smooth operation at 11:00 A.M., it culminated 4 hours later with 5180 Lorain County children between the ages of 1 through 7 years being immunized against Rubeola.

This number indicates a substantial proportion of the susceptibles, many of the remainder having previously been immunized in the offices of their private physician and the Health Department.

Over 200 volunteers served at the clinic sites, and included physicians, nurses, members of the Woman's Auxiliary to the Medical Society, and candystripers from the area hospitals. Success of the "Measles Sunday" was also assured not only by the co-operation of the parents, but by various civic organizations, school administrators, churches, merchants associations, boy scouts and others assisting in the several weeks of preparation prior to the project.

LUCAS

The June issue of the *Bulletin* of the Academy of Medicine of Toledo and Lucas County contains semi-annual committee reports. These summary reports are indicative of the broad activities of the Academy during the half year, and the many projects in which its members participate.

An "End Measles" campaign was held in Lucas County with the drive date as Sunday, May 21. Sponsoring organization was the Toledo-Lucas County Academy of Family Physicians. Physicians and other workers in the campaign set up clinics at 17 schools throughout the county on the designated Sunday.

OTTAWA

Members of the Ottawa County Medical Society, and the Auxiliary met for dinner and a meeting at the Catawba Cliffs Beach Club on May 11.

On June 8 the Society sponsored its annual picnic for the personnel and staff of the hospital at Port Clinton. The picnic was at the home of Dr. and Mrs. Donald Loeffler.

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Auxiliary Annual Meeting Report . . .

Convention Held in Columbus in Conjunction with OSMA Annual Meeting; Sessions in the Neil House

By MRS. S. L. MELTZER, Portsmouth
Chairman, Publicity Committee

THERE was something about the Neil House in Columbus that lent an aura of old-time dignity and grandeur to the 27th Annual Convention of the Woman's Auxiliary to the Ohio State Medical Association May 17 through May 19. It was particularly to be felt on the Mezzanine Floor of the old hostelry where so many memories of illustrious past events are ensconced in the huge ballrooms, the large meeting rooms, the wide foyer for registering and loitering and greeting. It was something one felt rather than something the eye caught. It heightened in some indefinable way (for your reporter at least!) this most recent annual meeting.

Always, of course, praise must be directed toward such vital, gracious women as Mrs. Samuel Saslaw, convention chairman, and Mrs. Floyd M. Beman, cochairman, and their innumerable committees (aided and abetted by Mrs. James N. Wychgel, President, and Mrs. Paul Sauvageot, President-Elect). I've said this before, and I say it again—those women who carry the burden of a convention do a remarkable job. Mrs. Saslaw and Mrs. Beman held the reins effectively and good-humoredly and knowingly. When a convention goes off so smoothly that it seems virtually effortless, you can be sure that the women at the helm and their assistants almost worked themselves to death!

This 27th annual meeting highlighted another first for the State Auxiliary—our presence, by invitation, at the opening session of the House of Delegates of OSMA at the Sheraton-Columbus. It was a privilege deeply appreciated. Dr. Lawrence C. Meredith, President, presided in an easy and effective manner. Dr. Robert E. Howard, President-Elect, gave a meaningful, inspiring inaugural address. Our own Ruth Wychgel presented the Auxiliary story and it was a terrific story to listen to! The Glee Club of the Montgomery County Medical Society "fought their way into tuxedos in early afternoon" (to quote Dr. Meredith) and delighted the audience with a truly professional musical program. From "This Is My Country" to "Shenandoah" to "Student Prince" to "Ole Man River," the voices of these gifted doctors raised in song provided the best in entertainment.

The first official business session of the Auxiliary convention got under way at 9:15 A. M. on Wednes-

day, May 17, presided over by Mrs. Wychgel, President. Mrs. William H. Evans, a Past National President and Past State President, served as parliamentarian. The meeting began with the invocation by Mrs. N. M. Reiff, another Past State President. Mrs. Evans directed the Pledge of Allegiance to the Flag, and the Auxiliary's Pledge of Loyalty. A cordial note of welcome was sounded by Mrs. James J. Conn, president, Franklin County, to which Mrs. Rudolf O. Cooks, president, Cuyahoga County, was privileged to give the response.

Dr. Meredith Speaks

Dr. Lawrence Meredith, the 1966-67 President of OSMA, greeted the House of Delegates and reminded the women that an earlier remark of his that "an OMPAC button and a winning smile were our most appropriate costume" had paid off well. "We helped in creating a welcome change in the 90th Congress," he said, "and Heaven knows, it needed it. Now we must prepare for next year . . ."

Mrs. O. M. Goodloe, Franklin County, introduced these out-of-state guests: Mrs. Frank Gastineau, National Past President and AMPAC Board member; Mrs. Raymond Jones, President, Kentucky Auxiliary; Mrs. S. Bruce Kephart, President-Elect, Indiana; Mrs. Charles C. Kissinger, President-Elect, Kentucky; Mrs. Rupert Powell, President-Elect, West Virginia; Mrs. Jack Ripp, President-Elect, Pennsylvania; Mrs. Henry Scovill, President, Michigan; Mrs. Wilson Smith, Immediate Past President, West Virginia; Mrs. Earl E. Weston, First Vice-President, Michigan.

Mrs. Wychgel then presented her convention chairman and cochairman. Several pertinent announcements and adoption of the Rules of Convention preceded the report on Roll Call. It was moved that the minutes of the 1966 convention not be read since they had already been published in the *Auxiliary News*. Motion approved. Mrs. R. L. Wiessinger submitted her treasurer's report. Motion to accept that report as audited approved. Before the first reading of the report of the Resolutions Committee, Mrs. Christopher A. Colombi, its chairman, read the section on Resolutions from the Bylaws. Following this, it was moved that the resolutions be considered as emergency resolutions. This had been recommend-

ed by the OSMA advisors because it had not been possible to meet the date deadlines as set up in the revision of the Bylaws. Motion carried. Resolutions were then given their first reading.

New Business

On the agenda under new business came the report of the Nominating Committee by its chairman, Mrs. Herbert F. Van Epps. Following this report, the President asked for nominations from the floor for each office on the first nominative slate for officers, district directors, and directors-at-large. Since there were no nominations from the floor, Mrs. Wychgel declared the nominative slate the elected slate. (See page 989 for names of new officers.) The President then asked for nominations from the floor for members of the 1967-68 Nominating Committee: From the Board, four to be nominated, two elected; from the membership, ten to be nominated, five elected. There being no nominations from the floor, it was moved that nominations as presented by the Nominating Committee be closed, subject to election Thursday afternoon between 3:00 and 5:30 P. M. Motion carried. Mrs. Wychgel called for nominations for delegates to the National Auxiliary convention in Atlantic City. Because of discussion on whether the Presidential Delegate was to be the outgoing or incoming President, it was voted first to take action on the amendments to the Bylaws before proceeding with these nominations.

Mrs. Fred Rittinger, Reference and Revisions chairman, presented several proposed amendments. The first had to do with Article III, Sections 2, 3, and 5. The change in this Article would make it possible for small counties to unite and become one component auxiliary, as is done in other states. What had been Sections 3, 4, and 5 would then become 2, 3, and 4 respectively. Motion was made for adoption of this amendment and carried. The second amendment had to do with Article V, Section 1 — changing the dues deadline date from January 15 to February 15. Motion made for adoption of this amendment carried. The third proposed amendment was in Article VII, House of Delegates, Section 2 — to be added: "members-at-large may be represented with one delegate and one alternate if they have 25 or more paid members in good standing and choose to be represented." Motion for adoption of this amendment carried.

The fourth amendment had to do with Article VIII — Officers — Section 2b — term of office — to which would be added: "The outgoing president and corresponding secretary shall complete all duties pertaining to their year in office until after National Convention and the outgoing president shall serve as the Presidential Delegate at the National Convention" — and to Sections 5, b-6 — duties of elected officers — to which would be added: "shall complete all duties pertaining to her term in office until after National

Convention and shall serve as Presidential Delegate at National Convention." The motion for adoption of this amendment was made and seconded.

Before action was taken on this amendment, however, it was moved that Mrs. John Dickie be privileged to speak (this action had to be taken since she had already spoken twice on the subject) and this motion carried. Then Mrs. Dickie presented an amendment to the amendment and moved its adoption: That the words "serve as Presidential Delegate" be deleted (in Section 2, b, and in Section 5, b-6) and the amendment read "the outgoing President serve as a delegate, give the Presidential report, and act as Chairman of Delegates at National Convention." This motion carried. A vote on the earlier motion for adoption of the original amendment was then called for, and that motion was defeated. The fifth amendment presented by Mrs. Rittinger had to do with Article XI — the new State Auxiliary Office — spelling out the necessary procedures and duties involved in the maintenance of such an office. Motion on this amendment carried. It was further voted that Article XI become Article XII, and what had been Article XII become Article XIII. Motion carried.

The business of nominating delegates and alternates to the National Convention was then resumed. It was moved that the list of proposed delegates to National Convention be accepted with the exception of Mrs. Paul Sauvageot, since she would automatically now be the Presidential Delegate. It was announced that voting on the delegates would also be held on Thursday afternoon between 3:00 and 5:30 P. M. The Election and Tellers Committee was introduced and voting instructions detailed. A report on the new Central Office was given by Mrs. Duane E. Banks. It was moved that the name of Mrs. Max Schnitker be substituted for that of Mrs. Ward Jenkins (who had become ineligible) in the list of nominees for the 1967-68 Nominating Committee.

Mrs. Gastineau

The high point of the morning was the inimitable and effervescent talk by Mrs. Frank Gastineau, a National Past President and only woman member on the AMPAC Board. Mrs. Gastineau was introduced by Mrs. Malachi W. Sloan, first vice-president. Mrs. Gastineau defined happiness as "getting invited to the Ohio Convention to see all my old friends."

She complimented Mrs. Wychgel and Mrs. Harry L. Fry, state legislation chairman, for the outstanding jobs they had done on OMPAC. "No one can be a good citizen," the former national president declared, "without being involved in politics . . . and never, never laugh at politicians." Doctors will stay out of politics, was another comment, when politicians stay out of medicine. At the finish of the lively, vigorous talk, it was moved that a letter of commendation be sent to Mrs. Gastineau. Motion passed by consensus.

The first business session was adjourned at 11:45 A. M. to make way for the luncheon in the West Presidential Ballroom honoring all county presidents. Members of the Licking County auxiliary served as hostesses. Auxiliary members were the guests of OSMA at the afternoon General Session at Veterans' Auditorium when Dr. Mary Calderone and Dr. Alan F. Guttmacher discussed "Educating Patients About Sexual Relationships."

At 3:45 P. M., Mrs. Wychgel presided over the session in which the county presidents highlighted their outstanding project of the year. Again these presidents evidenced clearly the dedication to the medical profession that underlies every Auxiliary project in which the doctors' wives engage. And on that Wednesday night, from 8:00 until 10:00 P. M., there was Open House at the new Central Office on North High Street, and it was heartening to witness the large number who turned out to see the Auxiliary's new home.

Second Session

On Thursday morning, May 18, the second business session was called to order by the President. It was moved that the reading of the minutes be disposed with because they will be printed. Motion carried. Roll Call chairman announced a total attendance of 89. Mrs. Colombi then gave the second reading of each of the four proposed Resolutions. Resolution No. 1 relative to high school driver education was voted upon and motion carried for its adoption. Resolution No. 2 relative to periodic motor vehicle inspection was voted upon and motion carried for its adoption. Resolution No. 3 relative to statutory definition of intoxication for drivers was voted upon and motion carried for its adoption. Resolution No. 4 relative to family life education was voted upon and motion carried for its adoption. Mrs. Colombi presented a Courtesy Resolution extending gratitude to the many individuals and groups who contributed to the success of the convention. Motion made for its adoption and carried.

Mrs. Ethel Swanbeck

Mrs. Harry Fry had the privilege of introducing the Honorable Ethel G. Swanbeck, State Legislator (and auxiliary member!) who discussed her role in the Legislature and the areas in which she is most interested—that of education, public welfare, and responsibility to the home and to good government. She reminded her audience "that there is no 'I' in the word team" and she suggested the women take a look at the two "I's" in the word Constitution "which belong to each of you . . . use them in building the world of tomorrow." She stressed good family relations, good family security and good spiritual values. At the conclusion of her dynamic talk, Mrs. Swanbeck was presented with Mrs. Wychgel's Civic Community Award in the Field of Legislation (her year's top priority). Also given a similar award was Mrs.

Harry L. Fry, Hamilton County, state legislation chairman, for her outstanding legislative efforts; and Mrs. Christopher Colombi, Cuyahoga County, a member of the Mayor's Committee for Employment of the Handicapped, for her outstanding contributions on behalf of the handicapped resulting in legislation on their behalf, showing that "One Woman Can Make A Difference."

Mrs. Calvin F. Warner, finance committee chairman, presented the report of her committee, including presentation of the 1967-68 budget. Motion for the adoption of the budget carried. With Mrs. Malachi W. Sloan, first vice-president in the chair, Mrs. Wychgel reported her year's stewardship to the House of Delegates and expressed her warm appreciation for the support she had been given through the Auxiliary year. She pointed out that legislation had top priority this past year. She remarked on the variety and ingenuity of community service projects and reviewed the activities of the various committees. Mrs. Wychgel spoke with obvious pride in the year's accomplishments, particularly the opening of the new Central Office. She spoke with similar pride of the fine job doctors' widows throughout the state are doing as continuing and vitally interested auxiliary members. She told of the contribution of WASA in memory of deceased Auxiliary members.

Credits and Awards

For the county auxiliaries, the "big" moment of convention was the presentation of Awards by Mrs. C. L. Johnson, Credits and Awards chairman. Thirty-nine local groups received the Certificate of Achievement with Gold Seal: Allen, Belmont, Butler, Clermont, Clinton, Coshocton, Columbiana, Cuyahoga, Clark, Delaware, Erie, Franklin, Fairfield, Geauga, Greene, Guernsey, Hardin, Huron, Hamilton, Knox, Lawrence, Logan, Lake, Licking, Lucas, Marion, Medina, Miami, Muskingum, Mahoning, Montgomery, Ottawa, Pickaway, Richland, Scioto, Stark, Summit, Trumbull, Tuscarawas. The four groups receiving the Certificate of Achievement without the Seal included Hancock, Jefferson, Lorain, and Sandusky.

Mrs. Calvin Warner introduced Dr. Robert E. Howard, President-Elect of OSMA, who greeted the House of Delegates and urged Auxiliary members to keep up their good work. Dr. Howard stressed the need for continued political activity and support of OMPAC. "We have a very small reserve," he pointed out. "We need this year to build up funds for next year's all-out campaign." He warned that "you cannot strengthen the weak by weakening the strong . . . you cannot help people permanently by doing for them what they can and should do for themselves."

Mrs. Evans, parliamentarian, detailed again the instructions for voting. Mrs. Wychgel adjourned the second business session at 12 noon, for the luncheon

honoring State and National guests. This Thursday luncheon had as its hostesses members of the Montgomery auxiliary. During the luncheon, Mrs. Jack W. Weiland, AMA-ERF treasurer, presented the annual awards: To Summit County which (for the third year in a row that I know of) contributed the largest amount of money for AMA-ERF — this time \$5,762.00; Muskingum which had a 91 per cent increase over last year; and Tuscarawas (at least three times in a row for them too!) which came through with the largest per capita contribution. Auxiliary members were again guests of OSMA at the afternoon General Session on "Drug Regulations and Compulsory Generic Prescribing." The participants included Dr. Perry R. Ayres, Editor, *The Ohio State Medical Journal*; Dr. Max S. Sadove, Professor and Head of the Department of Anesthesiology, University of Illinois Research and Educational Hospitals; and Joseph Stetler, of Washington, D. C., president, Pharmaceutical Manufacturers Association.

A special workshop occupied the period Thursday afternoon from 3:00 to 4:30 P. M.: A Parliamentary Procedure Workshop under the direction of Mrs. Rudolph O. Cooks. This workshop has proved a popular participation-type program which gives practical help at all auxiliary levels.

The OSMA Gaslight Party Thursday night was a rollicking, colorful "flashback" to the turn of the century and on and up into the Roaring Twenties. The food was a gourmet's delight — the entertainment packed with lively music, pretty girls, barber shop quartets — and dance music (two bands no less!) so tantalizing it was almost impossible to sit still!

Third Session

The Third Business Session got under way at 9:15 A. M. on Friday morning, May 19, Mrs. Wychgel presiding. Mrs. Herbert Van Epps took over the duties of parliamentarian. Again it was moved that the reading of the minutes be disposed with. Motion carried. Mrs. S. L. Meltzer, state publicity chairman, introduced Mrs. Karl F. Ritter, President-Elect, Woman's Auxiliary to the American Medical Association, whom she described as having "a quiet dignity, a quiet strength and tremendous competency." Mrs. Ritter expressed her delight at being present at the

Ohio convention (she had literally "dashed over" the night before from Duluth, Minnesota) and congratulated her home state on its fine record in Auxiliary work.

The report of the Election and Tellers Committee revealed these results of the previous day's voting for members of the 1967-68 Nominating Committee: Elected to that committee, from the Board — Mrs. James N. Wychgel, Mrs. Paul Jones; from the Membership — Mrs. J. F. Elliott, Mrs. Max Schnitker, Mrs. Richard Mills, Mrs. E. L. Jung, and Mrs. W. A. Campbell. Also announced were the results of the previous day's voting on the 17 delegates and 17 alternates to the National Convention in Atlantic City.

Mrs. John B. Hazard, state membership chairman, introduced Mrs. W. C. Scrivner, National North Central Regional Vice-President. Mrs. Scrivner urged that "we strengthen our membership, that we give a place of ourselves in friendship." She commented on Hamilton County's Apple Tree project and discussed certain legislative procedures. She mentioned that this year is the twenty-fifth anniversary of Margaret Wolfe's tenure of office as executive secretary to the National Auxiliary (who is herself the wife of a physician and an auxiliary member). And Mrs. Scrivner congratulated Ohio on being the first state to have its own Central Office. Mrs. Wychgel announced that a contribution is being made to a special fund for Margaret Wolfe in honor of her twenty-five years of service.

Installation

The installation of new officers was conducted by the National Vice-President in a meaningful and particularly effective ceremony. What made this ceremony so noteworthy and inspiring were the attractive and colorful symbolic velvet "badges" shaped like flowers. The significance of each color (there were six colors represented — blue, white, red, aqua, green, and purple) was beautifully detailed in connection with the duties of the particular officer being installed. Mrs. Van Epps assisted in the presentation of the "badges" of honor. Heading the newly-installed officials were Mrs. Paul Sauvageot as President and Mrs. Malachi W. Sloan as President-Elect.

THE WOMAN'S AUXILIARY TO THE OHIO STATE MEDICAL ASSOCIATION

President: Mrs. Paul Sauvageot
2443 Ridgewood Rd., Akron 44313

First Vice-President: Mrs. Edward L. Doerman
3605 Laskey Rd., Toledo 43623

Second Vice-President: Mrs. Carl F. Goll
1001 Granard Pkwy., Steubenville 43952

Third Vice-President: Mrs. Harry L. Fry
1071 Celestial St., Apt. 1804,
Cincinnati 45202

President-Elect: Mrs. Malachi W. Sloan, II
415 Towerview Rd., Dayton 45429

Recording Secretary: Mrs. James W. Loney
15450 Hemlock Point Rd., Chagrin Falls

Corresponding Secretary: Mrs. Duane E. Banks
1263 Jefferson Ave., Akron

Past President and Nominating Chairman:
Mrs. James N. Wychgel
3320 Dorchester Rd., Cleveland 44120

Treasurer: Mrs. Russell L. Wiessinger
2280 West Wayne St., Lima 45805

Mrs. Scrivner presented a check from the visiting VIP's — a gift for Ohio's AMA-ERF. Another check for AMA-ERF was presented by Mrs. Reuben Gould, president-elect, Cuyahoga County, in honor of Ruth Wychgel. Mrs. Roscoe Fidler, president of the Gavel Club (made up of state past presidents) presented the outgoing president with her past president's pin. Mrs. Fidler also presented a check from the Gavel Club for use for the Central Office.

Mrs. Wychgel then bestowed the president's pin on her successor, the newly-installed Mrs. Sauvageot, and turned over the gavel to her. Mrs. Sauvageot told the House of Delegates that what she had to say was not in the nature of an inaugural address but rather just some pertinent remarks. "All signs are 'go,'" she declared, "for a specially designated 'Ohio Auxiliary Week' all over the state, details of which will be announced later." The new President stressed the importance of good public relations and the need to tailor Auxiliary programs to the situations of the individual community. "Let us keep our own house in order," she commented further. "Let there be no pettiness . . . The Ohio Auxiliary is bigger and more important than any one personality." Mrs.

Sauvageot's closing remarks emphasized that it is high time for us to be counted as a prestige-group for service — "we should not have to beg for members; it should be a privilege to be a member."

Immediately following Mrs. Sauvageot's inaugural remarks, the twenty-seventh session of the House of Delegates of the Woman's Auxiliary to the Ohio State Medical Association was declared adjourned. The Summit County members were hostesses at a social hour that preceded the luncheon in honor of the new officers and board. And at 1:30 P. M., the Auxiliary attended OSMA's third General Session for the privilege of hearing Dr. Milford O. Rouse of Dallas, Texas, President-Elect of the American Medical Association, discuss "Current Problems Facing American Medicine."

One last orchid: To all those (and to Ruth Wychgel who came up with the idea!) who participated in the Hobby Show and made it such a tremendous success. Certainly there was never a more beautiful and fascinating display than that revealed by the artistry of so many talented Ohio auxiliary members.

Joint Federal-Ohio Drug Abuse Control Program Established

Announcement has been made that the Ohio Pharmacy Board has entered into an agreement with the U. S. Food and Drug Administration, Bureau of Drug Abuse Control, to administer local enforcement under provisions of the Drug Abuse Control Amendments of 1965 (FADA).

The Federal Act covers the legal distribution of certain stimulant and depressant drugs. The Ohio General Assembly recently passed a law covering the illegal possession and sale of LSD and other similar drugs.

The Drug Abuse Control Amendments of 1965 went into effect February 1, 1966, with a temporary exemption provided for certain stimulant and depressant drugs in combination form. On April 1, 1967, the temporary exemption expired, bringing into the picture hundreds of combination drugs. The FDA published in the *Federal Register* those combination products which are permanently exempted (*Federal Register*, Vol. 32, No. 5, January 10, 1967). This listing goes into minute detail as to dosages, etc., of hundreds of drugs.

At the request of the American Pharmaceutical Association, the FDA released a list of Drug Abuse Control products not exempt under the law as of April 1, 1967. An up-to-date revised list is due for release early in July, and periodically thereafter.

Under the terms of the agreement with the FDA, the Ohio Pharmacy Board is committed to the routine inspection of community and hospital pharmacies and

physicians' office record pertaining to drugs covered under the law.

The Ohio Pharmacy Board has agreed to investigate complaints involving Ohio pharmacists and physicians. The Federal Bureau will handle reports of large-scale diversions into illicit channels. The Federal Bureau also will continue its responsibility where drug manufacturers, packagers, wholesalers, and distributors are concerned.

The Journal will publish additional information on this subject, especially in regard to the types of drugs covered under the Federal and State laws.

Sixth District Postgraduate Day Plans and Theme Announced

The planning committee met recently and announced that the annual Sixth Councilor District Postgraduate Day will be held on Wednesday, October 25 in Warren at the Packard Music Hall, with the Trumbull County Medical Society as host organization. Program theme will be "Controversies in Medicine, 1967." Dr. George A. Sudimack, of Warren, is general chairman.

Dr. Richard L. Witt, associate professor of medicine at the University of Cincinnati, spoke at the annual meeting of the American Thoracic Society in Pittsburgh. He reported on a statewide respiratory disease screening program covering the metropolitan areas of Cincinnati, Columbus, Cleveland, Dayton, and Akron.

State Association Officers and Committeemen

Headquarters Office: 17 S. High St.—Suite 500, Columbus 43215. Telephone: (614) 228-6971

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SUMMIT—L. V. Phillips, President, 2106 Braewick Circle, Akron 44313; Mr. S. H. Mountcastle, Executive Secretary, 430 Grant Street, Akron 44311. 1st Tuesday monthly.

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HARRISON—Charles Evans, President, 159 South Main Street, Cadiz 43907; G. E. Vorhies, Secretary, Scio 43988. 3rd Wednesday, March, June, September and December.

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Cincinnatian Named Chairman of Thailand Advisory Committee

Dr. Richard W. Vilter, director of the Department of Internal Medicine at the University of Cincinnati College of Medicine, has been named chairman of an advisory committee for a clinical research center in Thailand. The center is sponsored by the U. S. National Institutes of Health and the Rockefeller Foundation with a grant of \$1,694,000.

To be located in the University of Chiangmai Medical School, the center will serve as a demonstration and training area for both American and Asian medical specialists in the investigation of anemias and tropical diseases.

Dr. Vilter's duties as chairman of the advisory committee will include an annual visit to Chiangmai University and additional meetings of the groups in the United States.



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The OHIO STATE MEDICAL Journal



VOL. 63 AUGUST, 1967 No. 8

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New Drugs Evaluated by the AMA Council on Drugs, 1967 Edition, published by the American Medical Association, 535 N. Dearborn Street, Chicago, Illinois 60610; \$3.50 in the U. S., Possessions, Canada, and Mexico; \$1.75 to medical students, interns, and residents.

This third annual edition of *New Drugs* has been revised to include new information; monographs on the recently introduced drugs have been added and many monographs and introductory sections from the 1966 edition have been improved and updated.

New Drugs has been planned to meet the specific needs of the practicing physician for a source of up-to-date, authoritative, and unbiased information on the more recently introduced drugs. Accordingly, it has been organized into chapters and sections that are based, insofar as possible, on the therapeutic classifications. Each chapter or major section thereof contains an introductory statement that briefly discusses the relationship of the newer drugs to each other and to older drugs.

The drugs that are discussed in detail in monographs are individual agents, generally available in the United States, that have been introduced within the past ten years. The statements on each of these drugs are based on an evaluation of the available


laboratory and clinical evidence by the Council and its consultants. Since a monograph on a drug is included whether or not the Council's opinion is favorable, *New Drugs* is in no sense a list of approved or accepted drugs.

The monograph for each new drug gives the adopted nonproprietary name; chemical or biologic identity; actions and uses, including comparisons with related drugs and limitations; adverse reactions; precautions; contraindications; drug interactions; dosage and routes of administration; preparations and their available sizes or strengths; known sources of supply, together with the commercial name or names of preparations marketed in the U.S. and other data.

Psychiatric Nursing Text

Dr. Charles K. Hofling, associate professor of psychiatry at the University of Cincinnati College of Medicine is coauthor of a text *Basic Psychiatric Concepts in Nursing*, the second edition of which has been published by J. B. Lippincott Company.

He wrote the text with Professor Madeleine Leininger, former director of the graduate program in psychiatric nursing of the University of Cincinnati College of Nursing and Health, who is now associated with the University of Colorado.



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Some Interesting Figures on Increase in Alcoholism

Alcoholism, long viewed by many as essentially a moral issue calling for social censure and punishment, is now increasingly being approached as a health problem requiring the combined skills of medicine, psychiatry, and sociology.

The exact number of alcoholics in the United States is unknown, but the latest estimate by the National Council on Alcoholism places it at 6,500,000, an increase of 1.5 million within a decade.

There were nearly 11,000 deaths attributed to alcoholic disorders in the United States in 1964. Almost three fourths of these deaths were reported due to cirrhosis of the liver with alcoholism, over a fifth to alcoholism, and the remainder to alcoholic psychosis. The reported death rate from alcoholic disorders has risen steadily in recent years—from 5.5 per 100,000 population in 1950 to 8.7 in 1964, an increase of nearly 60 percent over the period.

Higher death rates from cirrhosis of the liver with alcoholism accounted for most of the increase, while mortality from the other disorders showed little change during the past 15 years.

The upward trend in mortality from alcoholic disorders shows considerable variation by sex and race. The rise has been steeper for nonwhite persons than

for white, and for women than for men. Death rates for white men aged 20 and over rose almost 30 percent between 1950-51 and 1963-64, compared with over 90 percent for nonwhite men. Among women, the whites recorded a 75 percent increase and the nonwhites almost 150 percent.

Alcoholics are subject to distinctly higher than average death rates. A recent insurance study indicated that persons with a history of alcoholism experienced mortality $2\frac{1}{2}$ to 3 times higher than standard risks. The heaviest excess mortality was due to diseases of the digestive system, suicide, motor vehicle accidents, other accidents, and homicides.—Excerpt from Metropolitan Life Insurance Company Statistical Bulletin.

Film on Nutritional Therapy

Dr. David R. Weir, associate professor of medicine at Western Reserve University School of Medicine, is one of five participants on a medical teaching film entitled "Nutritional Therapy — Some New Perspectives." His discussions and illustrations center around four undernourished patients. The color, sound, 43-minute film may be obtained for showing to medical groups by writing: Squibb, 745 Fifth Avenue, New York, N. Y. 10022.

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Do You Know? . . .

Dr. Albert B. Sabin, of the University of Cincinnati Medical Center, was proclaimed "Matricola d'Onore," or honorary member of the University of Pavia, Italy, in recent ceremonies in that city. The honor included a gold emblem and traditional papyrus certificate, ringing of the town bells and a public announcement of the honor.

Dr. Norman H. Baker, Columbus, served a tour in Kabul, Afghanistan, as a member of a CARE-Medico team. His work was in the field of thoracic and cardiovascular surgery at the University of Nangrahar.

Dr. Richard B. Stoughton, Cleveland, director of dermatology at Western Reserve University School of Medicine, is the new editor of the *Journal of Investigative Dermatology*. Announcement of his appointment was made at the recent 30th annual meeting of the Society for Investigative Dermatology, which sponsors the journal.

Dr. Franklin C. Hugenberg, Columbus, recently went to Afghanistan for a tour of service under the CARE-Medico program at the Zoishgah Maternity Hospital in Kubal.

Dr. Frank J. Rack, Parma, general surgeon and proctologist, recently offered his services to the Volunteer Physicians for Vietnam program sponsored by the American Medical Association. He was scheduled to return from the two-months tour in mid-August.

Fall Meeting of Pediatricians In Washington Announced

The American Academy of Pediatrics will hold its 36th annual meeting in Washington, D. C., October 21-26.

Supplementing general session presentations, will be additional timely scientific programs presented Saturday and Sunday, October 21-22 during the meetings of the Academy Sections on Allergy, Anesthesiology, Cardiology, Child Development, Diseases of the Chest, and Surgery, and the Committee on Urology. The Section on Military Pediatrics will meet Tuesday, October 24.

Interested physicians may write the American Academy of Pediatrics, 1801 Hinman Avenue, Evanston, Illinois 60204, for a preliminary program and registration forms.



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A Six-Year Progress Report on Medical Education at OSU

"The immediate past six years have been a period of dynamic change in medical education and in the health affairs in our nation as a whole. These same six years on the Ohio State University campus have produced an era of change and significant progress involving the College of Medicine, its School of Nursing, School of Allied Medical Services, and the University Hospitals. . . ."

THE FOREGOING QUOTATION is from the introductory remarks of Dean Richard L. Meiling in a brochure type of report recently released by the Ohio State University College of Medicine. The report summarizes six years of progress in a program of extensive building, updating of equipment and facilities, and "intensive 'self-study' involving curriculum, teaching methods, students, alumni, and faculty."

Following are some excerpts, factual information, and comments taken from the report.

Academic Development

Beginning in 1962, the faculty has conducted annual "off-campus" seminars of from three to five days' duration. Guests from other universities have joined in the discussions of medical curriculum, student evaluation, students' acquisition of knowledge, and the presentation of "learning experiences" as differentiated from didactic teaching or lectures. The "faculty" for these seminars has been guest professors from other medical faculties.

In 1964, the faculty conducted a full year of intensive "self-study" of The Ohio State University College of Medicine. This involved students, alumni, and faculty. Financial support for these faculty studies has come from The Ohio State University Development Fund, the Association of American Medical Colleges, and friends of the College of Medicine.

The interviewing and selection of students to study medicine was moved to the College of Medicine buildings; a senior faculty committee to advise the Dean on appointments, promotions, and tenure was established; that students might concentrate on learning experiences in their professional educational development, the medical faculty with permission of the University abolished the customary grading procedures and now medical students receive either S (satisfactory), E (unsatisfactory) or H (honors).

The third and fourth years have become a 23-months' continuum during which students are per-

mitted to select seven months of electives. With permission of a department chairman, two to three months of such electives may be pursued on other campuses of this and other countries. Upon returning to this campus students meet with an evaluation group of the faculty of the department having granted original permission to study off-campus.

As a result of the "self-study" and the seminars, the faculty developed a course for first year medical students known as "The Behavioral Sciences" which allows the student during his first days in school to experience "patient contact."

A second course to arise from the seminars is the "Comprehensive Evaluation of the Patient." This course, which is "patient centered," is developed around a patient's particular complaint and the various means of obtaining the medical history and performing the physical examination, and of evaluation of diagnostic procedures, in such a manner as to increase the student's understanding as well as his skills in patient appraisal.

Each department annually has been provided non-appropriated funds to enable faculties to invite outstanding scholars from other universities.

Under the Department of Preventive Medicine all students are introduced to programs involving community oriented patient and health services. In collaboration with the Departments of Medicine, Pediatrics and Psychiatry programs are being developed in Family Medicine.

New departments of Physical Medicine, Pharmacology, and Medical Microbiology were established to make a total of 16 departments now in the College. Faculty committees are evaluating the possibility of additional departments to meet the academic needs of our students.

Upon the recommendation of the faculty, a Division of Research in Medical Education has been established and staffed in the Office of the Dean, thus incorporating educational development with scientific and medical progress. This is the seventh such division in the country. Under the guidance of this Division an auto-didactic (self-teaching) laboratory has been developed. Tape recordings, synchronized with automatic slide projection, may stimulate the student's learning. Closed circuit educational television has been established in surgery, obstetrics, and gynecology, physiology, and radiology. It is antici-



The painting reproduced on the brochure cover was presented to the OSU College of Medicine in October, 1966 by E. R. Squibb & Sons. The original in color is one of the *Collegia Medica* series sponsored by the pharmaceutical firm as a tribute to the most advanced system of medical education in the world.

pated that pathology, cardiology, and psychiatry will soon have similar television educational programs.

Each department chairman and member of the administration have attended conferences on computer applications in medical education and research.

Interdisciplinary seminars for the faculty have centered around cardiovascular teaching, physical diagnosis and cardiovascular research.

One of the serious problems of the College of Medicine has been the shortage of thoroughly competent faculty on regular contract to fulfill the essential functions of inspirational teaching, superior research and exemplary patient care. The College has worked diligently toward the strengthening of the faculty and great strides have been made in augmenting the teaching staff in medicine, nursing and allied medical services. From 1961 to 1966, the medical faculty has grown from 209 members on regular contracts to 341 and the School of Nursing from 43 to 56. The School of Allied Medical Services now has 35 faculty members.

Medical Students

Although medical students during 1965-66 came from 103 colleges and universities, 98 per cent of the student body are residents of Ohio.

To enhance the student's learning experiences the faculty desired to extend the patient-care educational programs to the community hospitals. Memoranda

of agreement between The Ohio State University and the Boards of the following Columbus hospitals have been accomplished for this purpose: Children's, Mt. Carmel, Riverside, St. Ann's, St. Anthony, Grant, and Harding Hospitals, and Sun Ridge Convalescent Center.

Two extra-curricular programs have been developed for the third and fourth year students. One is a full day conference sponsored by the Ohio State Medical Association to acquaint the student and his family with the environment of practice in a non-metropolitan community. This involves relationship with county commissioners, school boards, coroner, hospital boards, churches, etc. The other is a Dean's Seminar on "Financial Planning" — a full day's program with bankers, trust officers, insurance consultants, estate planners, tax experts serving as the faculty. These invitational instructional activities conducted off-campus are enthusiastically received by the students.

Postdoctoral Program

The curriculum committee of the faculty is engaged in an intensive study of the postdoctoral education program. All postdoctoral medical students (interns, residents, fellows, trainees, scholars, etc.) are now registered either as professional students or if they are working for an advanced degree, as grad-

(Continued on Page 1018)

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8.0 mg.
—
10.0 mg.
5.0 mg.
50.0 mg.
3.0 mg.
20.0 mg.
30.0 mg.
100.0 mg.

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of MEDIATRIC
LIQUID
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0.25 mg.
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—
5.0 mg.
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—
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—
—
—
—

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15% alcohol)

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tablets • capsules • liquid



(continued from page 1015)

uate students. During 1966-67 there are 109 interns, residents, and fellows who are working toward a degree in the Graduate School.

Research

The advancement of knowledge by means of research is an inseparable part of the mission of our College of Medicine. Each year has seen a steady growth in the amount of research conducted at the College of Medicine. The expenditures for research have grown from approximately \$1,015,000 in 1961 to the current level of expenditures for 1965-66 totaling \$5,190,492.55.

The legislative and executive branches of the state government have in the past six biennia, by providing direct appropriation to the University Hospitals for the support of research, made it possible for the College of Medicine to secure matching federal funds of an unrestricted nature in excess of a quarter million dollars each year for the stimulation of new faculty members and students. It also has made possible a marked increase in categorical research funds from the federal government and industry that have provided direct support of research and training.

During the six-year period there has been a great increase in the amount of student research. In 1960-61, as few as 17 students were participating in research supported through the College of Medicine in the amount of \$11,190. In contrast, in 1965-66, there were 129 students participating; support was \$99,544. It should be noted that this does not include a considerable number of other students who received support from the research grants of individual faculty members.

Continuing Medical Education

In 1962, a Center for Continuing Medical Education was established. The College of Medicine program in Continuing Medical Education, utilizing radio, telephone, and to a limited extent television, to reach the physician in his own community. Beginning in 1962 with 12 hospitals, the Ohio Medical Education Network, in 1966, now extends to western Pennsylvania, West Virginia, and Kentucky as well as 52 hospitals in Ohio. The Ohio Medical Education Network of our Center for Continuing Medical Education was honored by receiving "the 1966 Creativity Award" of the National University Extension Associations Division of Conferences and Institutes.

During the 1965-1966 school year the College sponsored 43 postgraduate courses of from one day to a month in duration. The attendance was 2,855 during 912 instruction hours.

The Ohio State Medical Association, the Ohio High School Athletic Association, the Ohio Academy of General Practice, the Ohio Chapter of the American College of Surgeons, and many other professional groups have co-sponsored courses, conferences, and seminars with the faculty. Travel clubs com-

posed of the outstanding clinical leaders of medicine and the National Consultants Group of the Surgeon General of the United States Air Force have all met on the campus and conducted scientific programs of an educational character.

School of Nursing

The peak number of Bachelor of Science in Nursing graduates was reached in 1965 with 167 who received degrees. A new graduate program in nursing service supervision was added in the fall of 1962. Graduate students studying for the Master of Science in Nursing rose from 23 to 58.

In January, 1965, the faculty of the School of Nursing was re-organized into eight major divisions to accomplish better two-way communications and a broader base for decision making.

In May 1964, the School of Nursing celebrated its Fiftieth Anniversary as a part of the Ohio State University with a two-day conference on Continuing Education. Ground breaking ceremonies for the 81,000 square foot Nursing School Building were held on September 21, 1966.

Allied Medical Services

President Fawcett, in 1962, directed the College of Medicine to conduct a feasibility study including cost centers for a proposed School of Allied Medical Services. In 1966 the School was established by the Board of Trustees bringing under one administration programs previously located in four colleges on the campus. The Board of Trustees established the School effective July 1, 1966. In fall quarter some 285 students were enrolled in this new school. Programs offered are as follows:

Degree: Medical Dietetics, Occupational Therapy, Medical Illustration, Physical Therapy, Medical Technology;

Certificate: Nurse Anesthesia, Orthoptics, Medical Illustration, Physical Therapy, Medical Technology, Radiology.

Other programs are under active study, one of which is a coordinated program with the College of Business Administration and Commerce in the field of Hospital Administration.

The Kellogg Foundation awarded a developmental grant to the College of Medicine of \$267,452 for the establishment of an educational and research program in Medical Dietetics for a six-year period beginning in October, 1961.

Other subjects dealt with in the report are an accounting of sources of funds and break-down of expenditures; numbers of faculty in each department; registration figures in each of the courses; function of University Hospitals in the program; historical sketch of the College of Medicine; long range plans of the College, etc.

An interesting chart shows distribution of 4,119 living alumni of the College of Medicine. Physician graduates of the college are in every county of Ohio and with one exception in every state of the Union.

Medicine's Not So Silent Partner

By the HON. DURWARD G. HALL, M.D.

Congressman, Seventh Missouri Congressional District

SINCE that crucial vote in the U.S. House of Representatives on April 8, 1965 when 286 House members defeated 191 opponents of federal medicine and Medicare started on its way—our profession has been asked by the federal government officials to join in partnership with the federal government, which is building bridges these days.

Leaders in all branches of Medicine freely offered their time and experience attending advisory committee meetings held in Washington, D. C. and Baltimore. Even some of the most liberal members of the radio, television, press, and periodical world who had been chewing on physicians for 20 years commended the professions new attitude of cooperation.

I, for one, urged cooperation then, and I urge it now, but its time to blow the whistle at the *fouls* being committed by Medicine's new "partner," or "intervener," the federal government. I know of no other profession, group or industry, certainly not labor, not the legal profession, not the professional chemists, or the professional engineers, who in spite of their good works and contributions to society, are the victims of such malicious invectives and accusations, as is the medical profession.

The Subtle Hand

In spite of being the only group which is subject to the draft up to age 35, in spite of the fact that many physicians give so generously of their time caring for the indigent, on unpaid hospital and other medical committees and boards, in medical missions in Vietnam and throughout the entire world, there is a growing long list of current smears, legal actions, punitive investigations, and intended regulations, some of which I will cite, and all of which demonstrate that with a friendly partner like this, who needs enemies?

Let me cite a few examples: . . . The Medicare law's legislative author, Mr. Mills, guaranteed on the floor of the House of Representatives that the Social Security Administration would not use the new law to disturb existing patterns of medical practice. Yet Mr. Ball, the Administrator, now proposes that hospital-based physicians, especially the pathologists and radiologists, become employees of hospitals.

. . . During the testimony before the House Ways and Means Committee prior to passage of the legis-

lation HEW officials vowed they wanted only to cover the 65 and older members of society, yet in the first session of Congress following enactment of the law, coverage of the disabled is requested—irrespective of whether such person is able to afford his own medical expenses.

. . . Though the law guaranteed two modes of payment for physicians, i.e., direct billing using receipted bill, or by the assignment method, just three weeks ago while organized labor stumped the nation and filled the press with charges that organized Medicine was ruining the program by not using the assignment route exclusively.

HEW officials, behind closed committee doors, sought to require a statement by the physician on his receipted bill that charges shown were his total charges, thus permitting the federal government to exercise fixed-fee-control over any physician in the Medicare program. This isn't "keeping the faith, baby," if you ask me, HEW's own testimony shows about half the doctors have used assignment during the first six months of the program.

Propaganda at Taxpayer Expense

. . . Disregarding the advice of the medical profession, our fair-weather partner sends its emissaries throughout the land, at the taxpayer's expense, in support of the use of "generic-drugs-only" in welfare programs.

. . . Pro-administration Senators Phillip Hart and Gaylord Nelson, who possess not a single hour of medical credit in their educational background, and whose professional staff rosters fail to include any medically trained personnel unless you count hangers-on of the Kefauver inquisition as such, tell the American people, who have the finest medical system in the world; that physicians must:

- a. Turn over to the optometrists some elements of care and treatment of the eye
- b. Must relinquish to the druggists the right to select from their stocks of generic drugs the drug of the company which offers to the druggist the highest mark up
- c. They would deny physicians the right to prescribe either a generic or trade name drug.

. . . Now Webster defines partner as—an associate; sharer; participant. The federal government is hardly living up to its role in this definition when its OEO

Text of a talk given before the annual Conference of Presidents and Other Officers of State Medical Associations, Atlantic City, N.J., June 17, 1967.

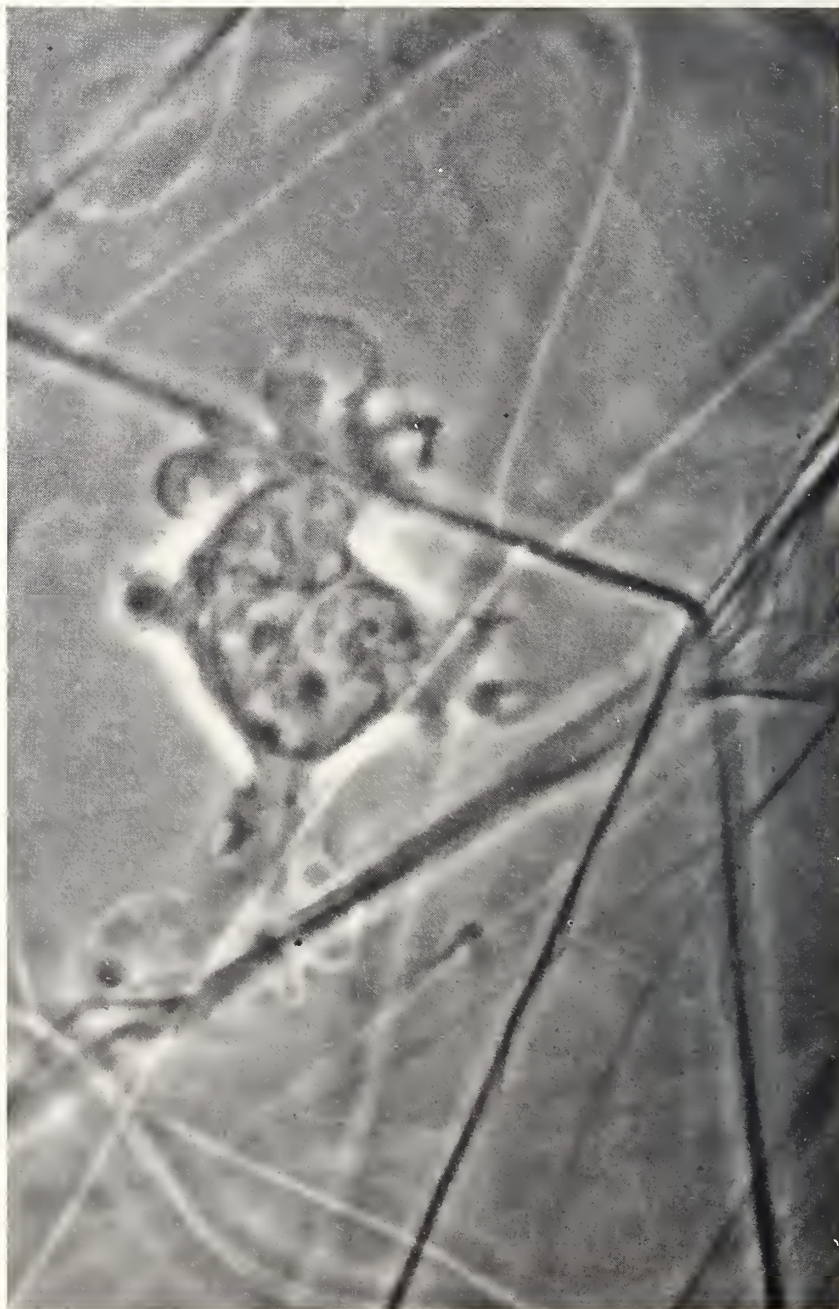
(Continued on Page 1028)

INFLAMMATION: A cellular fight for life

A SYNTEX REPORT based on recently developed hypotheses about topical corticosteroids, including the cellular theories of inflammation by Thomas F. Dougherty, Ph.D., University of Utah.

You are looking at a fibroblast fighting for life. This cell—one of the most common found in connective tissue—has literally been poisoned by cytotoxins released from other cells that have ruptured. Soon, if the abnormal activity of this fibroblast does not cease, it, too, will rupture and die—one more casualty in the inflammatory wave of destruction precipitated by injury.

Until a short time ago no one had ever witnessed such a scene at the cellular level. Now, through advanced cinemicrographic techniques, it is possible to view and photograph the inflammatory process as produced experimentally in living animal tissue. This method permits new insight into the mechanism of inflammation and the role of corticosteroids in therapeutic management. Equally important, these techniques shed new light on factors that may make one corticosteroid more effective than another—factors that can be correlated with other chemical, biologic, and clinical parameters.



Worldwide clinical experience confirms the predictable therapeutic potential of Synalar

It is particularly gratifying that the promise of the advanced chemical design and high order of bioassay activity of Synalar (fluocinolone acetonide) has been confirmed by widespread therapeutic application. Indeed, the impressive clinical response rate of Synalar has been documented in no fewer than 232 papers from 22 countries.

PRESCRIBING INFORMATION

For initiation of therapy: Cream 0.025%, 5 and 15 Gm. tubes, 425 Gm. jars; *for emollient effect:* Ointment 0.025%, 15 Gm. tubes; *for maintenance therapy:* Cream 0.01%, 15 and 45 Gm. tubes, 120 Gm. jars; *for intertriginous or hairy sites:* Solution 0.01%, 20 cc. and 60 cc. plastic squeeze bottles; *for infected inflammatory dermatoses:* Neo-Synalar® Cream (0.025% fluocinolone acetonide, neomycin sulfate, equivalent to 0.35% neomycin base), 5 and 15 Gm. tubes.

CONTRAINDICATIONS: Tuberculous, fungal, and most viral lesions of the skin, (including herpes simplex, vaccinia, and varicella). Not for ophthalmic use. Contraindicated in individuals with a history of hypersensitivity to any of the components. **PRECAUTIONS:** Synalar preparations are virtually nonsensitizing and nonirritating. However, the solution may produce burning or stinging when applied to denuded or fissured areas. In some patients with dry lesions, the solution may increase dryness, scaling or itching. While topical steroids have not been reported to have an adverse effect on pregnancy, the safety of their use on pregnant females has not absolutely been established. Therefore, they should not be used extensively on pregnant patients, in large amounts, or for pro-

Representative Clinical Results with Synalar*

Efficacy Documented in over 4,000 Patients

Condition	Number of Publications	Number of Patients	Significant Improvement†
Contact Dermatitis	27	750	713
Eczematous Dermatitis	21	472	409
Seborrheic Dermatitis	18	442	426
Atopic Dermatitis	24	460	426
Psoriasis	36	1,699	1,510
Neurodermatitis	18	351	324
Total	144	4,174	3,808

*Complete bibliography on request.

†Expressed by the authors as excellent, very good, good, complete remission of inflammation, etc.

longed periods of time. Prolonged use of any antibiotic may result in overgrowth of nonsusceptible organisms; if this occurs, appropriate therapy should be instituted. When severe local infection or systemic infection exists, the use of systemic antibiotics should be considered, based on susceptibility testing. **SIDE EFFECTS:** Side effects are not ordinarily encountered with topically applied corticosteroids. As with all drugs, however, a few patients may react unfavorably to Synalar under certain conditions. The neomycin in Neo-Synalar Cream rarely produces allergic reactions.

REFERENCES: 1. Lerner, L. J., Bianchi, A., Turkheimer, A. R., Singer, F. M., and Borman, A.: Anti-inflammatory steroids: potency, duration and modification of activities. *Ann NY Acad Sci* 116:1071 (Aug. 27) 1964. 2. Idem: Comparison of anti-granuloma, thymolytic and glucocorticoid activities of anti-inflammatory steroids. *Proc Soc Exp Biol Med* 116:385 (June) 1964. 3. Ringler, A.: Activities of adrenocorticosteroids in experimental animals and man, in Dorfman, R. I.: *Methods of hormone research*, New York, Academic Press, 1964, vol. III, pp. 234-280. 4. Gubersky, V. R.: To be published.

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those of systemic corticosteroids
with fewer hazards

opens neighborhood clinics in cities where the local medical society's notice of the event is seen for the first time in a copy of the evening paper of the day of the grand opening. This has happened in several places—most recently, in my own state, in Kansas City. Nor is the government playing the game when, in its demonstration cities' legislation there is provided mortgage guarantees wherein preference is given to those groups who offer prepaid care. These usually are labor organizations' plans wherein physicians are hired on a salary and their earnings exploited in a way contrary to medical ethics.

"Profit" Taxes on Revenue

... Nor is the federal government a friendly partner when in return for such good deeds as the voluntary Vietnam Medic Program for the civilians of that war torn country, its Commissioner of Internal Revenue proposed regulations to tax at the rate of 48 per cent net, advertising revenue of national and state medical journals and the journals and magazines of nearly every cultural organization in this country including the Boy Scouts and the Girl Scouts, the American Bar Association, the American Farm Bureau, the U.S. Chamber of Commerce, and I could go on naming some 600 educational, scientific, service, and cultural organizations whose members are from the professions, business, and labor.

These proposed regulations are based upon a 1950 (17 year old) law originally enacted by Congress to curb the abuse of tax free universities owning and operating manufacturing businesses in competition with tax paying businesses.

Our friendly partner's IRS has recently notified the Student American Medical Association that it is recommending withdrawal of the Association's status as a tax exempt organization. IRS says the group derives most of its income from advertising revenues

in its magazine, the *New Physician*, and from sales of life insurance to its members.

Though we all know that voluntary community blood banks are organized "not for profit," and reduces costs of medically needed blood, yet our "friendly" partner's FTC claims they are a business, and in interstate commerce, and therefore are subject to the antitrust laws.

First Step in Harassment

Our friendly partner's Justice Department has filed a civil antitrust suit charging the College of American Pathologists and its members with conspiring to monopolize the medical laboratory testing industry by price-fixing and forcing laboratories, owned by nonmembers, out of business by what it called "boycotting agreements." As you know the College pointed out that the timing of this action, coming as the inception of Medicare and immediately following the AMA Annual Meeting, makes it appear that this is but the first step in a campaign of harassment of the entire medical profession by the government.

There are times when the American public can hardly escape the conclusion that the Administration in power is deliberately out to destroy the good name of the American physician, and to make him a subject of ridicule and contempt. For those who in one pious breadth attack "McCarthyism" and in the other breadth use such broad brush methods of innuendo, there is a double standard of immense contradictions.

I am still convinced that cooperation is the best road to travel, but cooperation which must be in its best and truest and fullest meaning. It must work both ways, and those representing quality care of patients must have the guts to stand for belief and principle.



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Rising Hospital Costs . . .

American Hospital Association Report on What It Calls the “Unprecedented Cost Increases” Hospitals Are Experiencing

EDITOR'S NOTE: The following report released by the American Hospital Association is presented because of the broad background of information it presents.

HEALTH SERVICE is a personal service provided by people to people. Behind all the statistics and the graphs, this one fact remains the nub of the complex and troubling problem of the spiraling cost of hospital care today.

Hospitals are what the economists call “labor intensive” organizations. Two-thirds or more of their total costs are in payroll, and only one-third in materials, supplies, and other overhead expenses.

With business and industry, it is exactly the reverse.

This is primarily because hospitals, unlike business and industry, require personal service by employees to patients, 24 hours a day each day of the year. For the most part, these personal services cannot be replaced by machines at a lower cost, as has been the case in industry generally. Not if the quality of care, the high level of medical technology which has enabled America's hospitals to provide such dramatic, life-saving advances in the last 20 years, is to be maintained.

Health Worker Ratio

Twenty years ago hospitals had to employ one and a half persons to take care of each patient. Today the ratio is almost three to one. In 1940, there were five health workers for each physician in this country; in 1950 there were seven; in 1960 there were 11. Today there are 13 health workers for every physician, and by 1970 the ratio probably will be 17 to 1.

This ratio probably will continue to rise. The more a high level of health care is made available to every person in this country, the more the quality of health care is improved by advancing medical technology, the more people—highly trained and high priced people—will be required to take care of the patients in the nation's hospitals.

This is the reason why the breakthrough in salaries for hospital employees this year—the first major breakthrough since 1946—has had such an escalating effect on hospital costs. It is predicted that hospital costs will probably continue to rise steeply for the next three to five years, although hospital leaders believe they will level off as hospital wages catch up with those of business and industry.

The U. S. Department of Health, Education, and Welfare released a report in March showing that hospital costs rose 16 per cent in 1966, compared with an average 7 per cent per year increase for the previous five years. American Hospital Association projections are for a rise in total hospital expense per patient day of 18.6 per cent for the period September 30, 1966 to September 30, 1967; and a 30.2 per cent increase from September 1965 to September 1967.

These estimates are based on figures in the accompanying table.

Based on these projections, the AHA predicts for the two-year-period an increase of nurses salaries by 30 per cent, an increase in all other salaries by 25 per cent, and an increase in expenses other than payroll by 11 per cent. At the same time, the projection is for an increase in the number of full-time employees by 5.1 per cent, and an increase in the average daily census of 3.4 per cent.

ESTIMATED PROJECTIONS FOR RISE IN HOSPITAL EXPENSES PER PATIENT

	Year End 9/30/65	Year End 9/30/66	Year End 9/30/67
Total full time equivalent employees	1,386,000	1,466,000	1,541,000
Total staff nurses	277,000	293,000	308,000
Total other personnel	1,109,000	1,173,000	1,233,000
Total expense per patient day	\$44.48	\$48.83	\$57.93
Salary expense per patient day	\$27.44	\$29.88	\$36.90
Other expense per patient day	\$17.04	\$18.95	\$21.03
Average salary all personnel	\$4,072	\$4,382	\$5,140
Average daily census	563,000	569,000	588,000

Factors in Spiraling Costs

Factors contributing to this spurt in hospital costs include the spiraling cost of materials and supplies, other effects of the regular inflationary cycle, additional costs of doing business with Medicare, and the expense of keeping up with a rapidly advancing and quickly obsolescent medical technology.

It is generally agreed, however, that the skyrocketing payroll costs have been the major contributing factor. Hospital salaries have jumped from 20 per cent to as much as 40 per cent in some areas of the country—triggered by last summer's nurses "strikes" for higher salaries and by the inclusion of hospitals under the Federal Minimum Wage legislation as of February 1, 1967. The basic cause behind this sharp increase this year was the acute shortage of all health manpower, plus the fact that, as late as 1962, the average hospital worker in this country was earning wages at a rate considerably lower than the average worker in industry. It is this great gap that hospitals now are attempting to close.

Comparison with Industry

The particular vulnerability of hospitals as a "labor-intensive" industry to increases in salaries and wages can be seen from the following comparison with industry.

In the first place, while industry generally is able to absorb the effect of wage increases through in-

creased productivity, this is not true of hospitals, where payroll constitutes two-thirds or more of total costs, and where personal service can be automated only to a limited extent.

Secondly, the impact of wage increases on general hospital costs is much greater than the effect of equal increases on the costs of industry. In fact, the same per cent increase in the hourly rate paid to hospital personnel and to industry could have more than double the effect on the total hospital cost as compared to cost to industry.

For example, it is generally accepted that payroll makes up about 26 per cent of the total corporate operating expenditures for the nation. During 1965 hospital wages accounted for almost 62 per cent of total hospital expenditures. Thus the 23.5 per cent increase (\$29.88 vs. \$36.90—see statistical table) in hospital wage rates predicted for the year ending September 30, 1967 would raise hospital costs by 14.5 per cent (61.7×23.5).

On the other hand, the same 23.5 per cent increase in general industry hourly wage rates would raise their costs only by about 6.11 per cent (26×23.5).

Putting this another way, with a national hospital staffing pattern today of 2.8 persons per patient, each 5 per cent an hour wage increase produces a hike in actual cost to the hospital of \$1.12 (5×22.4 hours).

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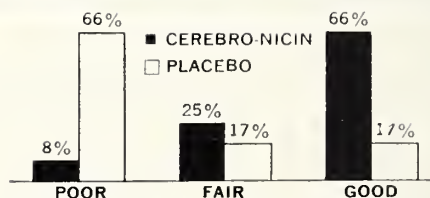
Pentamethylene Tetrazole	100 mg.
Nicotinic Acid	100 mg.
Ascorbic Acid	100 mg.
Thiamine HCl	25 mg.
L-Glutamic Acid	50 mg.
Niacinamide	5 mg.
Riboflavin	2 mg.
Pyridoxine	2 mg.

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*A Double-Blind Study of Cerebro-Nicin, Therapy for the Geriatric Patient, R. Goldberg, Jnl. of the Amer. Ger. Soc., June, 1964.

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*prediluted and sterilized

1. Carson, M., and Hart, L.: "New Perspectives on Nutritional Aspects of Modified Milk-Fat Formulas," Colloquium held under the auspices of The Pediatric Department, Western Reserve University School of Medicine at Cleveland, Ohio, Sept. 8, 1966. Data available on request.

2. Hegner, R.: *ibid.* 3. Nichols, M.: *ibid.* 4. McCann, M.L.; Teree, T., and Wallace, W.: *ibid.*

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American College of Physicians Schedules Cincinnati Course

The American College of Physicians has released its list and description of regional postgraduate courses for the 1967-1968 season beginning in September. Information on some 21 courses is available from the college at 4200 Pine Street, Philadelphia, Pa. 19104.

One course entitled "Intensive Care Units" is scheduled in Cincinnati, February 19-23, 1968. It is described as follows:

University of Cincinnati Medical Center and Cincinnati Veterans Administration Hospital, Cincinnati, Ohio; A. William Schreiner, M.D., F.A.C.P., director; Gene F. Conway, M.D., codirector, Minimal registration, 10; maximal registration, 15.

The course is designed to review recent knowledge and experience in the diagnosis and treatment of patients with critical medical illness and to observe the operation of an intensive care unit, a coronary care unit and related facilities. Topics to be covered will be myocardial infarction, pulmonary insufficiency, shock, cardiopulmonary resuscitation, electrolyte disturbances, stroke, coma, and GI bleeding. Demonstrations and practical experience will be furnished with monitors, respirators, blood gas determinations, defibrillators, and cardiac pacing equipment in the Intensive Care Unit, Coronary Care Unit and clinical cardiopulmonary laboratories. There will be discussions of the planning, staffing, and equipment of intensive care and coronary care units.

Organization for Social Health Reports on Vice Prevalence

Among excerpts from annual reports of the American Social Health Association is the following item: In 1966, ASHA investigators made 78 community studies in 35 states to determine the extent and availability of commercialized prostitution. Fifty-three cities received satisfactory ratings; 25 did not. In those cities with satisfactory ratings, a diligent search might reveal a prostitute. In those cities with poor ratings prostitutes openly solicited, often catering to Armed Forces personnel.

ASHA regional staff focused on cities with poor ratings, consulting with community leaders to stimulate action to reduce prostitution and related vice activities. . . . — *Social Health News*.

UC Medical Alumni Officers

Dr. Joseph N. Freiden, class of '33, was installed as president of the University of Cincinnati College of Medicine Alumni Association for 1967-1968. Other officers are Dr. John E. Albers, past president; Dr. Albert D. Weyman, chairman of the Executive Council; and Dr. Calvin F. Warner, executive secretary-treasurer. Dr. Charles S. Blase, was named editor of the *Medical Alumni Bulletin*.

Drug Firm Reduces Prices on Certain Key Products

The following news item is presented in behalf of one of the leading pharmaceutical manufacturers because of its news value to the medical profession as well as to the general public.

Prices of quinine, quinidine, and colchicine products, forced upward in recent years by spiraling costs of raw materials, have been cut by Eli Lilly and Company. The reductions are approximately 10 per cent for quinine formulations, 15 per cent for quinidine, and 16 per cent for colchicine products.

Raw materials costs to the Lilly company increased sharply in recent years. In 1966 the company paid five to six times as much for quinine and quinidine as it had paid two years earlier. The cost of colchicine rose even more sharply.

In the face of such increases, the company last year was forced to raise prices of its formulations of the three drugs, but the changes were nothing like those seen in raw materials costs.

A Lilly spokesman said the current price cuts are possible because Lilly economists have projected lower and more stable costs for raw materials in the future.

"It is our policy," the Lilly spokesman said, "to make available to patients the anticipated savings as soon as possible. These products must be taken over long periods of time because of the chronic nature of the illnesses they treat. It is important that any hardships worked by the temporary high prices due to raw materials costs be minimized as soon as practicable."

New Members . . .

Following are names of new members of the Ohio State Medical Association certified to the Headquarters Office during June. List shows name of physician, county, and city in which he is practicing or temporary addresses for those taking graduate work.

Cuyahoga

Howard J. Klein, Cleveland
Leroy F. Smith, Jr., Cleveland

Franklin

Aziz Alasyali, Columbus
James D. Bowers, Columbus
Byron K. Cole, Columbus
William R. Toler, Worthington
Huseyin A. Turkoglu, Columbus
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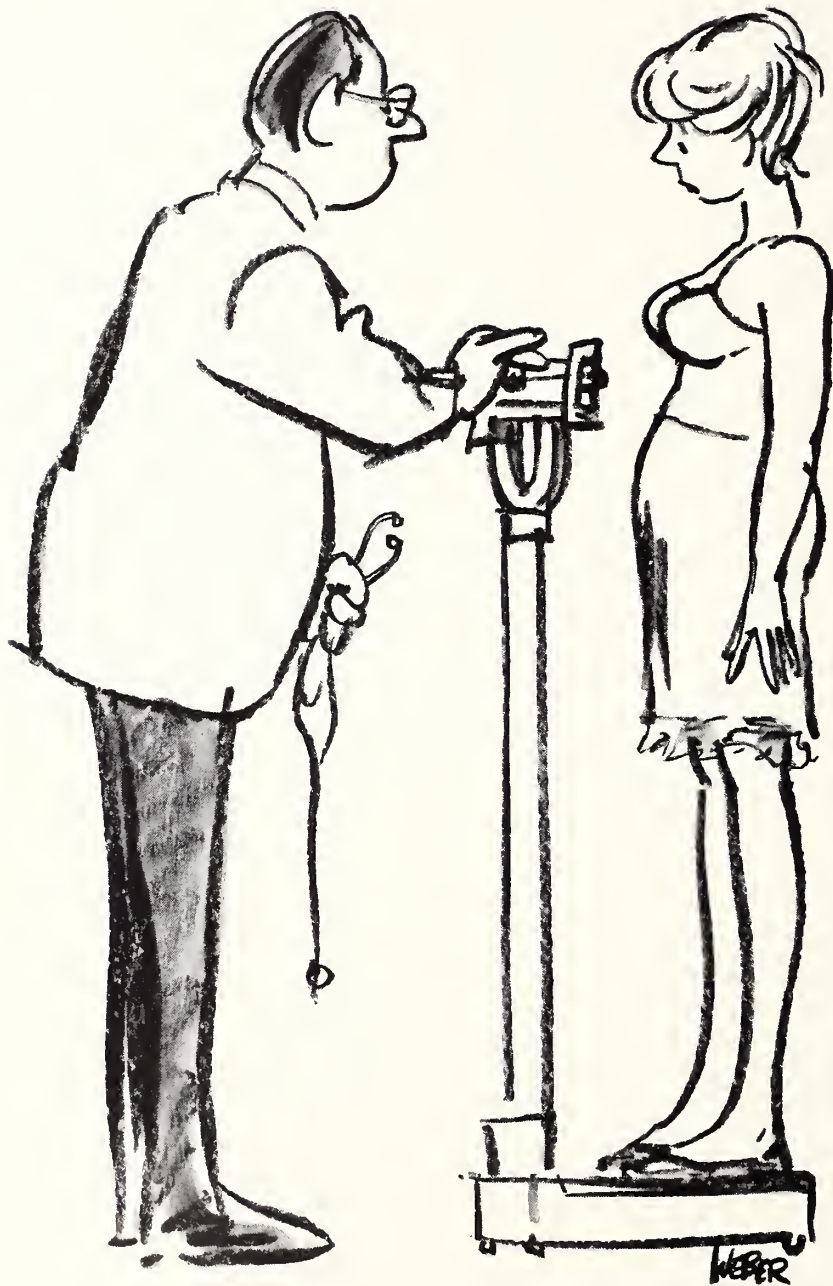
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Dextro-amphetamine sulfate: Excessive use by unstable individuals may result in psychological dependence.

Meprobamate: Careful supervision of dose and amounts prescribed is advised, especially for patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on the drug. Where excessive dosage has continued for weeks or months, reduce dosage gradually. Sudden withdrawal may precipitate recurrence of preexisting symptoms such as anxiety, anorexia, or insomnia; or withdrawal reactions such as vomiting, ataxia, tremors, muscle twitching and, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, reduce dosage and avoid operation of motor vehicles, machinery or other activity requiring alertness. Effects of excessive alcohol consumption may be increased by meprobamate. Appropriate caution is recommended with patients prone to excessive drinking. In patients prone to both petit and grand mal epilepsy meprobamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities to patients

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Side Effects: Overstimulation of the central nervous system, jitteriness and insomnia or drowsiness. Dextro-amphetamine sulfate: Insomnia, excitability, and increased motor activity are common and ordinarily mild side effects. Confusion, anxiety, aggressiveness, increased libido, and hallucinations have also been observed, especially in mentally ill patients. Rebound fatigue and depression may follow central stimulation. Other effects may include dry mouth, anorexia, nausea, vomiting, diarrhea, and increased cardiovascular reactivity.

Meprobamate: Drowsiness may occur and can be associated with ataxia; the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdose may produce drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

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Cincinnati Radiological Heritage

The First Fifteen Years

STANLEY LUCAS, M.D.*

PART III

(Continued From July Issue)

THE *Cincinnati Lancet Clinic* noted the fifth meeting (1904) of the American Roentgen Ray Society at St. Louis, Missouri. The subjects of interest during this year were the demonstrations of urinary stones, use of x-ray over the spleen in the treatment of leukemia, and a report on sarcoma of the orbit treated with x-ray by Dr. Pfahler.

In January, 1905, Dr. Albert H. Freiberg, the well known Cincinnati orthopedic surgeon, and later Professor of Orthopedic Surgery at the University of Cincinnati, gave an excellent discussion of the use of the radiogram in orthopedic diagnosis. He noted the limitations of fluoroscopy, stressed the knowledge of normal anatomy, the importance of a compression diaphragm for study of thick parts, the need for periodic restudy of parts, and realized that x-ray had already become an indispensable aid in the practice of orthopedic surgery. In discussion of this paper, Dr. Joseph Ransohoff, the occupant of the Chair of Surgery at the Medical College of Ohio in Cincinnati, noted "the finest radiograph is still very difficult of interpretation."

Dr. D. T. Vail, the editor of *Ophthalmology of the Cincinnati Lancet Clinic*, presented four cases of ocular trauma which were referred to Dr. W. J. Taylor for x-ray diagnosis and detection of foreign bodies.

Dr. James E. Coleman of Canton, Illinois, in a paper on the "Value of X-Ray To The General Practitioner" published by the *Cincinnati Lancet Clinic* in February, 1905, noted that the treatment of acne had been the most satisfactory. However, he also reported that his

most brilliant success has been in the treatment of the case of epilepsy — according to the techniques of Braith. . . . During a period extending over several months — the patient has not had a single attack.

He also described treating over the kidney for albuminuria, with good results in one case. He treated one case of infected gallbladder which was

inoperable. He felt that the value of treating lupus was well established and thought that the use of x-ray was helpful in tuberculosis for suppression of mucus production.

On discussing the paper, Dr. Edwin H. Shields felt that the general practitioner would be better off without the use of x-ray. He felt that x-ray was not useful for the relief of pain, and that surgery was easier, if at all possible, for epitheliomas. With regard to the use of x-ray for acne, he said that he had seen cases of permanent pigmentation and shriveling of skin. In his great dissatisfaction with x-ray, he continued "that now with the x-ray, the orthopedic surgeon can see his mistakes and is not able to rectify many of them."

In rebuttal, Dr. Coleman said that "our friend tells us that it is not a good idea to have a good view of the bone, because you will know too much. *I think knowledge is better than ignorance.*" He felt that damage to patients' skin would not occur if you use "short sessions." "I do not think that Dr. Shields had a high frequency current." Dr. Shields in response said "I use a high frequency current, but no electrode." Dr. Coleman rebutted "it is the electrode that gives the result, and that probably explains the fact that Dr. Shields is losing faith."

Dr. Myron Metzenbaum of Cleveland, Ohio read a paper before the Mississippi Valley Medical Association in Cincinnati, October, 1904 entitled "Radium — Its Value in Medicine." He discussed the treatment of lupus, rodent ulcers, and small epitheliomas with hermetically sealed tubes of radium, ranging from "100 activity to 7,000 activity."

Further disappointment with x-ray was noted in 1905. Dr. Heidingsfeld, Professor of Dermatology at the Cincinnati Polyclinic and Post- Graduate School of Medicine and later to become internationally known for his work in x-ray therapy and syphilotherapy and also later the Director of The Department of Dermatology at the Cincinnati General Hospital, wrote

the longer we use the x-ray, the less favorable and more skeptical are our impressions regarding its unflinching ef-

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Submitted October 24, 1966.

ficacy in certain directions. . . . Its application is so purely mechanical, and its administration is so well and generally so clearly understood by almost every quack and tyro, that its assumed superior technique counts for little or nothing.

In April, 1905, editorially the *Lancet Clinic* reported on the use of x-ray in leukemia. They noted a patient who was treated over the spleen for a long period of time subsequently developed a nephritis and felt that this might be related, however remotely, to the radiotherapy. [Probably radiation nephritis.]

Dr. Meyer Heidingsfeld and Dr. A. J. Markley, Clinical Lecturer in Dermatology, in an article in the *Lancet Clinic* entitled "Some Dermatological Abuses," noted that the prolonged or careless use of the x-ray could be productive of epitheliomas and decried against the indiscriminate use of the x-ray as a cure-all. Dr. William J. Taylor defended the use of x-ray if legitimately used in selected cases. Dr. Elmore Tauber said "now that we are getting older in its use, we are getting better results." Dr. Horace J. Whitacre noted "x-ray will not influence deep-lying cancers."

Dr. William J. Taylor, in February, 1905, demonstrated the apparatus designed by Dr. William M. Sweet, of Philadelphia, for the location of foreign bodies in the eye by the use of x-rays.

The name of Dr. Sidney Lange (Fig. 4), a man whose life spanned many years with large contributions to the practice of Radiology nationally and in Cincinnati, author of many scientific papers and



FIG. 4. Sidney Lange, M.D.—A pioneer radiologist, a large contributor to x-ray literature and president of the American Roentgen Ray Society in 1914. Courtesy—Eugene Saenger, M.D.

President of the American Roentgen Ray Society in 1914, first appeared in the *Lancet Clinic* in 1905 when he noted his difficulties in localizing foreign bodies in the eye by means of a Sweet Localizer if more than one foreign body was present. A notice in July, 1905, indicated that Dr. Sidney Lange had safely arrived in Hamburg, Germany and for four



FIG. 5. H. Kennon Dunham, M.D. (1872-1944)—Internationally known for his early work on determination of x-ray quantity and on the roentgen diagnosis of pulmonary tuberculosis. Medical Portraits (Striker).

or five months, he planned to study in Berlin, Paris, Vienna, and London, the trend of the time for those interested in specialization.

The announcement of the sixth annual meeting of the American Roentgen Ray Society to be held at Johns Hopkins University, September 28, 29, and 30, 1905 noted that papers on the first day would deal with x-ray diagnoses and those of the second day would deal with therapeutics, an early cleavage of the two major radiological branches.

In a paper by Dr. Duncan Eve of Nashville, Tennessee, in the September, 1905 *Cincinnati Journal* on "The X-Ray in the Treatment of Fractures" he commented

to suggest that it is the surgeon's duty in all cases to employ the x-ray is perhaps making a statement too strong. . . . In order to get the best results from the roentgen ray, not only must the apparatus be good, but *the man that uses it must have experience.*

In December 1905, Dr. Mark Brown editorially noted for the first time the importance of the use of x-ray for medical-legal purposes in that

damages have been awarded to patients in malpractice suits apparently for no other reason than that the x-ray was not used in diagnosing a condition.

Dr. Joseph Ransohoff reported the use of x-ray in diagnosing kidney stones and commented upon the importance of duplicating the observations of the stone on several plates. His x-ray plates for demonstrations were apparently taken by Dr. Albert Freiberg. In the discussion, Dr. Oliver, commented on plates taken by Dr. Marion Whitacre (both surgeons) in which artefacts due to finger marks gave the false appearance of stones.

Toward the end of 1906, in the *Cincinnati Journal* appeared the name of Dr. H. Kennon Dunham (Fig. 5), a man so important in the early years of the x-ray as a champion of accuracy and detail and later

Associate Professor of Medicine, Head of the Department of Tuberculosis at the University of Cincinnati and internationally known for his work focused chiefly on the roentgen diagnosis of pulmonary tuberculosis and the control of the disease. Dr. Dunham read a paper on x-ray technique, December 18, 1905, in which he noted that the greatest stumbling block in x-ray therapy was the difficulty in obtaining a definite and permanent unit of measurement for the x-ray. He discussed many technical details, including the use of radiochrometers of Benoist and Holzknecht for determination of x-ray quality. He also discussed the use of filters in eliminating the soft rays for the preservation of the skin. He went into great detail in describing proper methods of treating various conditions. He noted

there have been many criticisms of radiotherapy upon this floor but I believe that every one of them can be explained by the fact that they were born of imperfect knowledge, gained either from faulty observation or imperfect technique.

In 1906, Dr. William McDowell Doughty graduated from Miami Medical College and started an internship at the Cincinnati General Hospital. He later was to become another of the physicians who played an important role in the practice of radiology in Cincinnati.

Dr. Dunham, continuing his quest for specificity and accuracy in both the diagnostic and therapeutic uses of x-ray, and at that time lecturer of electrotherapeutics at the Medical College of Ohio, wrote a comprehensive paper on a measure of the quantity of x-ray in the latter part of 1906. He described several instruments which recorded quantity of x-ray by changes of flow of current.

The *Cincinnati Journal* announced the seventh annual meeting of the American Roentgen Society, August 29, 30, 31, 1906, at the Cataract and International Hotels, Niagara Falls, New York with an economy note that the railroads granted a rate of a fare and a third on the certificate plan.

(Continued in September Issue)

Rhode Island Medical Society History Covers 150 Years

The History of the Rhode Island Medical Society and Its Component Societies, 1812-1962 has just been published by society which has its headquarters at 106 Francis Street, Providence, R. I. 02903.

In 1960 the Council of the Rhode Island Medical Society authorized the preparation of a history of the Society as part of the then approaching Sesquicentennial Celebration (1962). Because of the numerous problems involved in such an extensive project, publication date was delayed.

In the book, the 150 year history of the Society is divided into three sections, covering 50 years each. A history of each of the district societies is included.

The Rhode Island Society is the eighth oldest state society in continuous operation.

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Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently.

Warning: If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with great caution in the first trimester of pregnancy.

Precautions: Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should be closely supervised and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools or other evidence of intestinal hemorrhage. Make regular blood counts. Discontinue the drug and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The most common are nausea, edema and drug rash. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. Infrequently, agranulocytosis, or a generalized allergic reaction may occur and require withdrawal of medication. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

Dosage in Painful Shoulder: 600 mg. daily in divided doses for 2 to 3 days; 300 mg. daily thereafter. Usual duration of therapy: 2 to 7 days.

Availability: Tablets of 100 mg.

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Scientific Section

VOL. 63

AUGUST, 1967

No. 8

Acid-Base Measurements A Review Emphasizing Clinical Application

FREDERICK GOETHE SMITH, M. D.

ANY PHYSICIAN who has attempted to follow the recent literature concerning acid-base balance must feel overwhelmed by the various and often conflicting viewpoints presented. If the physician learned acid-base balance 20 or 30 years ago, he finds the newer terminology confusing. This is not for lack of many excellent papers and monographs which explain the principles in detail.¹⁻⁴ Rather, the difficulty stems from an excess of explanation, and a failure to present in simple form the standards by which the physician can measure alterations in acid-base balance. It is the purpose of this paper to define and clarify those laboratory measurements of acid-base balance, which the clinician can use in the management of his patients.

At the outset, it must be understood that the laboratory cannot diagnose the cause of an acid-base disturbance. Only the clinician, by careful history and observation, will be able to determine the primary cause, and the mechanisms by which the secondary compensations have been effected. Furthermore, the laboratory data pertain only to a sample of whole blood, obtained at a particular time, which does not necessarily reflect accurately the acid-base status of the interstitial fluid, or spinal fluid,⁵⁻⁶ and certainly not the intracellular fluid. The rates of diffusion of carbon-dioxide and the bicarbonate-ion are different, consequently the ratios which obtain in blood do not necessarily apply to the body as a whole. Since it is the ratio of dissolved CO_2 to bicarbonate-ion which determines the acidity of the extracellular fluids, this difference in rate of diffusion may be very important in a situation of rapidly changing CO_2 or bicarbonate.

The Author

● Dr. Smith, Marion, Ohio, is Chief of Surgery, Community Memorial Hospital, and a member of the Active Staff, Marion General Hospital; Assistant Professor, Department of Surgery, The Ohio State University College of Medicine.

Within these broad limits what help may the clinician obtain from the laboratory? There are four factors of acid-base balance which can be determined:

1. CO_2 content.
2. Partial pressure of carbon-dioxide (PCO_2).
3. pH.
4. Buffer base or bicarbonate.

The details of laboratory procedures need not concern us. The familiar " CO_2 combining power" has been discarded as insufficiently accurate. All essential information can be derived from a determination of " CO_2 content" and pH. The CO_2 content of whole blood is determined by gasometric analysis; pH is measured with a glass membrane electrode and a potentiometer. PCO_2 and bicarbonate may then be calculated from the Henderson-Hasselbalch equation, or obtained from suitable tables⁷ or nomograms.⁸ Technical refinements, such as the use of microtechnics for pH determination, PCO_2 electrode,⁹ and the Astrup determination of whole blood buffer and "Base-Excess"¹⁰ further extend the usefulness of the laboratory in appraising acid-base disturbances.

The blood sample may be arterial, "arterialized" venous, or capillary blood. For infants, and for pa-

tients requiring repeated study, microtechnics permitting the use of capillary blood are especially desirable. The specimen must be obtained anaerobically, with heparin as an anticoagulant, and should be examined within 20 minutes, or refrigerated until analysis can be performed. The use of sodium fluoride to inhibit metabolic changes in the blood sample is not recommended.¹¹

"CO₂ Content"

"CO₂ content" is a misnomer. Actually, the CO₂ content of plasma includes:

1. Bicarbonate (HCO₃⁻) 24.0 mM.
2. Dissolved CO₂ 1.2 mM.
3. Carbonic acid 0.0017 mM.
4. Carbamino CO₂ 0.5 mM.

Total "CO₂ content" 25.7 mM./L

CO₂ content by itself gives no clue as to what portion is bicarbonate, and what portion is carbon-dioxide. As an isolated test it has limited value in the appraisal of acid-base disturbances. Since the major portion is bicarbonate, the test is useful in gauging metabolic disturbances in which ventilatory function is grossly normal to clinical examination. By itself the test is useless in assessing respiratory disturbances.

PCO₂

The amount of carbon-dioxide present in physical solution in the blood plasma depends upon the partial gas pressure of carbon dioxide (PCO₂). For each millimeter Hg pressure exerted by CO₂ gas, 0.0301 millimol of CO₂ dissolves in each liter of plasma, at normal body temperature. This amount is constant for a body temperature of 38° C., consequently the constant 0.0301 x PCO₂ in mm. Hg will indicate the concentration of CO₂ in mM per liter of plasma. Approximately 1/700 part of the dissolved CO₂ is hydrated to carbonic acid in the plasma.¹² This very small quantity of carbonic acid is the chief source of free hydrogen-ion in the blood.

Arterial blood is in equilibrium with the gases in the pulmonary alveoli. The arterial PCO₂ is therefore an index of pulmonary function. Increased ventilation results in a fall in PCO₂ while decreased ventilation causes a rise in PCO₂.

pH

The pH is indicative of the concentration of free hydrogen-ion in the blood plasma. By definition pH is the logarithm of the reciprocal of the hydrogen-ion concentration. Most clinicians find the mathematics of pH obscure, and utilize the values only as an arbitrary scale which vaguely indicates the normal, high, and low range of hydrogen-ion concentration. The actual concentration of hydrogen-ion is exceedingly small; at normal blood pH of 7.40 it amounts to approximately 0.00004 mEq H⁺-ion per liter.¹³

This can also be expressed in *nano-equivalents* (nEq), one nano-equivalent being one-millionth of 1 mEq.¹⁴ Expressed this way, blood at pH 7.40 contains 40 nEq hydrogen-ion per liter. The relation of pH to nEq is as follows:

pH	7.0	100 nEq	} — Acidemia
	7.1	80 nEq	
	7.2	63 nEq	
	7.3	50 nEq	
	7.4	40 nEq	Normal
	7.5	32 nEq	} — Alkalemia
	7.6	25 nEq	
	7.7	20 nEq	
	7.8	16 nEq	

To illustrate graphically the extremely small amount of free hydrogen-ion present in normal blood plasma at pH 7.40 would require a Gamblegram of heroic proportions (Fig. 1). If one could show H⁺-ion in the cation column allowing 1 millimeter height

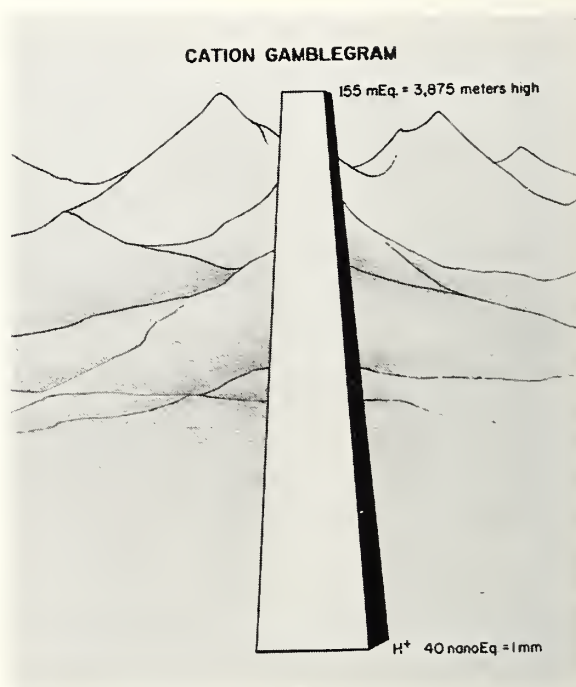


FIG. 1. Graphic representation of the small quantity of free hydrogen-ion in relation to the total cations in plasma at pH 7.40.

to represent 40 nEq of H⁺, then the total height of the column representing 155 mEq of cation would be 3,875 meters, or 12,600 feet, just 1,500 feet less than the height of Pike's Peak!

The point is this: The clinician should choose the representation of hydrogen-ion activity which best suits his own conceptual needs. Whether this be pH or concentration in nano-equivalents is of no consequence. The activity of the hydrogen-ion so profoundly affects vital processes that H⁺ concen-

trations greater than 126 nEq/L (pH 6.9) or lower than 16 nEq/L (pH 7.8) are incompatible with life.

The pH or hydrogen-ion concentration reflects the state of physiologic balance between respiratory removal of CO_2 and the level of the plasma bicarbonate. An arterial pH in the normal range of 7.40 indicates a state of balance in which normal hydrogen-ion concentration has been maintained. A pH outside the normal range indicates a failure to fully compensate for changes in PCO_2 or bicarbonate. Taken by itself the pH or hydrogen-ion concentration cannot indicate the severity of an acid-base disturbance. The pH or hydrogen-ion concentration is meaningful only when considered in conjunction with the PCO_2 and the plasma bicarbonate.

The interplay of bicarbonate and PCO_2 in determining pH is expressed mathematically by the Henderson-Hasselbalch equation. Unfortunately, this involves logarithms and seems pretty mysterious. On the contrary, if we make use of hydrogen-ion concentration instead of pH, we get rid of those troublesome logarithms and have a simple problem in arithmetic. The general form of the CO_2 : Bicarbonate equation may be stated:

$$[\text{H}^+] = K' \frac{\text{Dissolved } \text{CO}_2}{\text{Bicarbonate}}$$

K' is the dissociation constant; if $[\text{H}^+]$ is expressed in nano-equivalents, then the numerical value of K' is 794*. To make the arithmetic easy K' can be rounded out to 800. The dissolved CO_2 is the product of the solubility constant \times pressure of CO_2 ($.03 \times \text{PCO}_2$). The equation then becomes:

$$[\text{H}^+] = 800 \frac{.03 \times \text{PCO}_2}{\text{HCO}_3^-}$$

Under normal conditions with PCO_2 40 mm Hg and HCO_3^- 24 mEq/L, it is easy to see that $[\text{H}^+]$ amounts to 40 nEq/L, and it is easy to see that, however much PCO_2 and HCO_3^- may change, it is their ratio which determines the hydrogen-ion concentration.

Now a word of caution: the statement of a finite quantity of free hydrogen-ion, however small, may be a simpler concept for the clinician than dealing

*The value of K' when $[\text{H}^+]$ is expressed in equivalents per liter is 7.94×10^{-7} . To compute pH by the Henderson-Hasselbalch equation one uses the logarithm of the reciprocal of K' which is designated $\text{p}K'$.

$$\text{p}K' = \log \frac{1}{K'}$$

$$\text{p}K' = \log \frac{1}{7.94 \times 10^{-7}}$$

$$\text{p}K' = 6.1$$

$$\text{pH} = \text{p}K' + \log \frac{\text{Bicarbonate}}{\text{Dissolved } \text{CO}_2}$$

$$\text{pH} = 6.1 + \log \frac{\text{HCO}_3^-}{.0301 \times \text{PCO}_2}$$

with the logarithmic scale of pH values. Nevertheless, it is the pH of blood which is measured in the laboratory, and this is the value which the clinician may expect to see reported. The pH is an electrical measurement of H^+ -ion activity per kilogram of water, and the precise factor for converting this activity to H^+ -ion concentration per liter is not known.¹⁵ For simplicity it is usually assumed that the activity factor may be taken as 1.0 and that

$$\text{pH} = \log \frac{1}{[\text{H}^+]}$$

according to the standard definition of pH. This is the basis for the scale of values given above. Whether these values truly represent millionths of milliequivalents of H^+ -ion per liter of plasma is not significant. It is the activity of the free H^+ -ion and not the physical quantity which is important. This activity may be expressed in logarithms on the pH scale, or exactly the same grades of activity can be expressed by actual numbers using nano-equivalents.

The Buffer Base

The very low level of hydrogen-ion present in the blood is due to an abundance of hydrogen acceptors known as buffer bases. These buffers act like sponges to soak up any excess of free hydrogen-ion in the body. The principal intracellular buffers are proteins and phosphates. In the blood, hemoglobin, plasma protein, and bicarbonate are the important buffers. Interstitial fluid, being poor in protein, is buffered mainly by bicarbonate.

Although both intracellular and extracellular buffers play a part in acid-base disturbances, only the blood buffers can be measured. Whole blood with a hematocrit of 40 per cent contains approximately the following quantities of base¹:

Hemoglobin	22.60 mEq
Plasma protein	7.89 mEq
Bicarbonate	19.51 mEq
Buffer Base	50.00 mEq/L whole blood

If strong acids such as lactic acid or aceto-acetic acid accumulate in the body, the buffer bases accept the hydrogen-ions, and there is a corresponding fall in the total available base remaining. If hydrogen-ions are lost through vomiting or gastric suction or if bicarbonate is gained through exogenous routes, the buffer bases are correspondingly increased. The level of the buffer bases is, therefore, indicative of any metabolic alteration in acid-base balance.

There is no uniformity of opinion as to the best way of reporting metabolic changes in the buffer bases. Originally, attention was focused on the bicarbonate. In 1948 Singer and Hastings¹⁶ proposed the whole blood buffer base as a better index of acid-base disturbance. This approach was subsequently modified by Astrup¹⁰ through the concept of the titratable base as an excess or deficit in relation

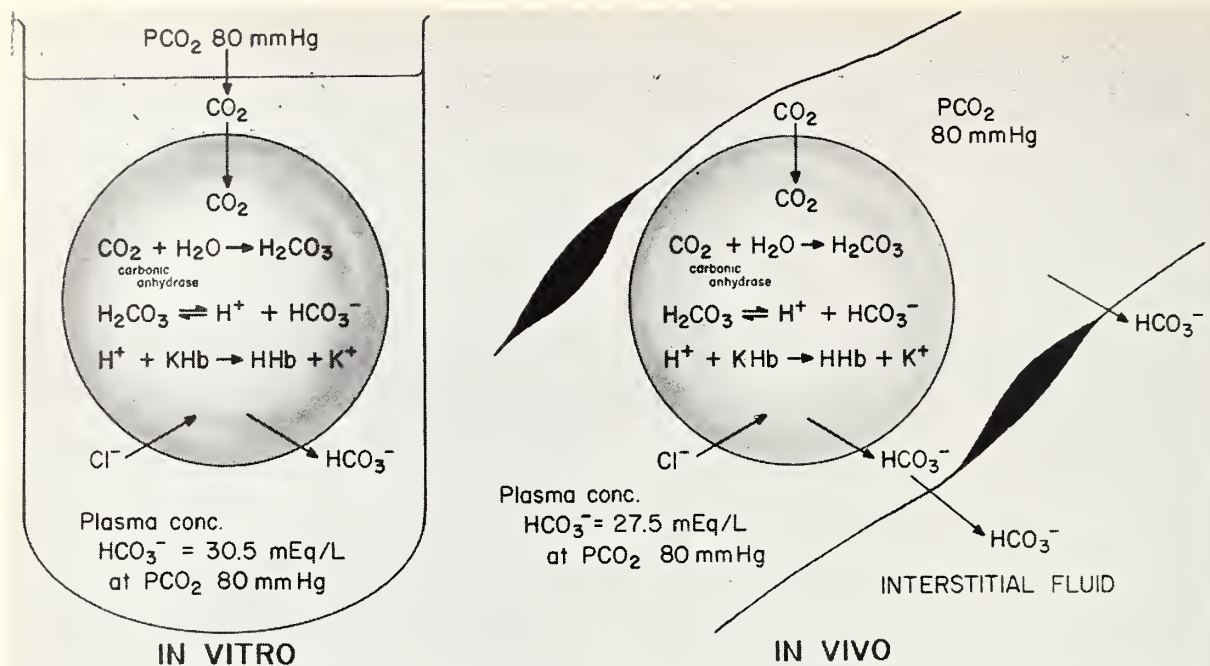


FIG. 2. Equilibration of whole blood with CO₂ at partial pressure of 80 mm. Hg. In vitro the bicarbonate-ion formed inside the erythrocyte diffuses into only the plasma. In vivo the bicarbonate diffuses through the capillary wall and equilibrates with the much larger interstitial space.

to the normal values. Each approach has its proponents and detractors.

Changes in PCO₂ do not directly affect the total buffer base. As the PCO₂ increases, dissolved CO₂ diffuses into the red cells. Inside the cells, the enzyme carbonic anhydrase acts to hydrate the dissolved CO₂ to H₂CO₃. The H₂CO₃ ionizes to produce hydrogen-ion (H⁺) and bicarbonate anion (HCO₃⁻). The hydrogen-ion is buffered by hemoglobin, and most of the bicarbonate diffuses out of the red blood cells into the plasma. The amount by which the hemoglobin base diminishes is exactly offset by the bicarbonate produced. The *in vitro* equilibration of blood with increasing partial pressures of CO₂ raises the plasma bicarbonate from 15 mEq at PCO₂ 10 mm. Hg to 32 mEq bicarbonate at PCO₂ 90 mm. Hg. The 17 mEq of bicarbonate formed corresponds to 17 mEq H⁺-ion accepted by hemoglobin and plasma protein. The total buffer base is not changed.

In vivo a rise in PCO₂ produces exactly these same chemical reactions in the blood. *In vivo*, however, the reaction involves the whole body and is not confined to a blood sample in a test tube (Fig. 2). Some additional bicarbonate is formed in body cells, and some bicarbonate diffuses out into the interstitial fluid.¹⁷ The net effect is that *in vivo* an acute rise in PCO₂ produces less rise in plasma bicarbonate than occurs when whole blood is equilibrated with the same PCO₂ in the laboratory. This apparent lowering

of the bicarbonate values in acute hypercapnia is not due to the accumulation of metabolic acid and has no effect on total body buffers. As will be shown, it makes necessary a special *in vivo* scale of "normal" values for actual bicarbonate.

Actual Bicarbonate: The actual bicarbonate of the patient is the plasma bicarbonate present under the condition of PCO₂ existing in the body at the time of taking the sample. *Actual bicarbonate* rises with increase in PCO₂ and with metabolic alkalosis, and falls with decrease in PCO₂ and with metabolic acidosis. The *actual bicarbonate* can be used as a gauge of metabolic acidosis or alkalosis by making use of a scale of "normal" values derived from *in vivo* experiments. Table I is a scale of "normal" values for *actual bicarbonate* for PCO₂ values ranging from 10 to 90 mm. Hg. The table was constructed from the Siggaard-Andersen nomogram⁸ for PCO₂ 10 mm. through 40 mm. Hg. In this lower part of the scale the *in vitro* and *in vivo* scales are essentially the same.¹⁷ For PCO₂ values above 40 mm. Hg Table I lists the average HCO₃⁻ values found experimentally by Brackett, Cohen & Schwartz¹⁸ in human volunteers subjected to acute hypercapnia.

Standard Bicarbonate: To avoid the need for this extended scale of "normal" values for bicarbonate it is possible to use the "standard bicarbonate." The term "standard" signifies that the plasma bicarbonate is measured under standard conditions as follows:

full oxygenation of whole blood at PCO₂ 40 mm. Hg and 38° C.¹⁵ The standard bicarbonate reflects the metabolic changes in acid-base balance. The normal value for standard bicarbonate is 24 mEq per liter of plasma.

Standard bicarbonate depends upon the *actual bicarbonate* and therefore also is affected by acute hypercapnia. The loss of bicarbonate to the interstitial fluid must be taken into account in making use of the *standard bicarbonate* in the presence of acute hypercapnia. Acute hypercapnia will have the effect of lowering the standard bicarbonate about 2 to 4 mEq/L without signifying the accumulation of metabolic acids.

Whole Buffer-Base: The whole buffer-base, including hemoglobin and plasma protein, more accurately reflects metabolic changes in acid-base balance than does bicarbonate alone. The whole buffer-base in mEq/L is inconvenient to use clinically since the "normal" total will depend upon the amount of hemoglobin present. For example, a patient in normal acid-base balance with 15 Gm. hemoglobin has a buffer-base of 48 mEq/L, while another patient in normal acid-base balance with 8 Gm. hemoglobin has a whole buffer-base of 45 mEq/L. In anemia the lesser amount of buffer-base residing in hemoglobin, is partially offset by the increased proportion of protein and bicarbonate in the plasma fraction of a liter of whole blood. The quantity of buffer-base falls with metabolic accumulation of acid and rises with metabolic loss of hydrogen-ion or accumulation of bicarbonate.

Base Excess: From the clinical standpoint we are not interested in the total quantity of buffer-base. Our concern is with the net gain or loss of available base through metabolic disturbances of acid-base balance. This change in buffer-base is best expressed as the base excess or deficit.^{10, 19} *Base excess* (B.E.) is the amount of titratable base or acid present in the blood when titrated to pH 7.40 at PCO₂ 40 mm. Hg at 38°C. Base excess (B.E.) values are reported as mEq per liter, a positive sign denoting an excess, and a negative sign a deficit. The B.E. measures quantitatively the degree to which the whole blood buffer has been altered either by primary metabolic acidosis or alkalosis, or as a metabolic compensation for respiratory acidosis or alkalosis. The values so obtained then can be applied to therapy. Once more, one must be reminded that in acute hypercapnia there is a loss of bicarbonate into the interstitial fluid which lowers

TABLE 2. *Normal values arterial blood, adults living near sea level, Temperature 38° C.*

pH		
Men	7.360	7.420
Women	7.376	7.420
PCO ₂ mm. Hg		
Men	41.2	± 2.5
Women	38.1	± 2.5
Standard Bicarbonate		
Men	22-25	mEq/L
Women	22.5	25 mEq/L
Base Excess (B. E.)		
Men	-2.4	to + 2.3 mEq/L
Women	-3.3	to + 1.2 mEq/L

From Gambino, et al.¹¹ Report of Ad Hoc Committee on Methodology, in *Current Concepts of Acid-Base Measurement*.

TABLE 3. *Normal Acid-Base Values Under Special Conditions*

a. High Altitudes: PCO_2 decreases with acclimatization to high altitudes. PCO_2 falls approximately 4.2 mm. Hg for each 100 mm. Hg decrease in barometric pressure. With full acclimatization pH is normal and bicarbonate proportionately reduced.
(Kellogg²¹ and Pugh.²²)

b. Pregnancy: Dyspnea is commonly associated with pregnancy; PCO_2 is moderately reduced, bicarbonate reduced, and pH remains normal.
(Prowse and Gaensler.²⁸)

c. Newborn Arterial blood:

Age:	1-4 hrs.	12-24 hrs.	24-48 hrs.	96 hrs.
pH	7.30	7.38	7.39	7.39
PCO_2 mm. Hg	39.	33.	34.	36.
Actual bicarbonate	18.8	19.5	20.	21.4

(Avery, and Normand.²⁴)

d. Infant 3-24 Mos.

pH	7.398 ± 0.027
PCO_2	33.8 ± 3.7 mm. Hg
B. E.	-3.2 ± 1.7 mEq/L

(Albert and Winters.²⁵)

the whole blood buffer and results in a depression of the B.E. by approximately 2 mEq.²⁰

Assessment of Acid-Base Disturbances

There are three questions which the laboratory can answer concerning acid-base disturbances—all others must be answered by the clinician.

1. *Is carbon dioxide being removed at a normal, increased or decreased rate?*

This question is answered by the PCO₂.

2. *Is there an increase or decrease in hydrogen-ion concentration?*

(Text Continued Next Page)

TABLE 1. *"Normal" Values of Actual Bicarbonate*

PCO ₂ mm. Hg	10	20	30	40	50	60	70	80	90
HCO ₃ — mEq.	15	19	22	24	25.8	26.5	27.1	27.5	27.9
(all values HCO ₃ — ± 1.5 mEq.)									

From Siggaard-Andersen⁸ for PCO₂ values to 40 mm. Hg.
From Brackett, Cohen, & Schwartz¹⁸ for PCO₂ values above 40 mm.

(Continued)

The blood pH or the hydrogen-ion concentration in nano-equivalents conveys this information. It indicates the degree to which compensatory processes have succeeded in maintaining a normal balance.

3. *Is there a metabolic alteration in the blood buffers which has raised or lowered the amount of base available to accept hydrogen-ions?*

Any one of three values can be used to answer this question.

- a. Actual bicarbonate
- b. Standard bicarbonate
- c. Base Excess (B.E.)

The clinician must choose the parameter which best suits his purpose.

All other questions in the assessment of acid-base disturbances are the province of the clinician. From the history and physical examination, and the evolution of the disease process, the clinician must seek answers to the following:

1. What are the underlying causes and mechanisms of the acid-base disturbance?
2. Which process, metabolic or respiratory, is primary, and which is compensatory?
3. Is more than one primary acid-base disturbance operating to produce a mixed disturbance (such as would occur if a patient with diabetic acidosis, suffered also from respiratory acidosis due to ventilatory insufficiency)?

These clinical questions are beyond the scope of this paper; they are listed as a reminder that only by such total assessment can the disturbance be fully understood and adequate treatment prescribed.

Summary

1. To define an acid-base disturbance properly, the laboratory analysis must include the blood PCO_2 , the pH, and a measurement of the available base (actual bicarbonate, standard bicarbonate, or Base Excess).
2. PCO_2 indicates the rate of removal of CO_2 by pulmonary ventilation.
3. Blood pH is a logarithmic expression of the activity of the exceedingly small quantity of free hydrogen-ion present. The hydrogen-ion concentration may be expressed in millionths of milliequivalents as nano-equivalents. Blood of normal pH 7.40 may be considered to contain 40 nano-equivalents of free hydrogen-ion. This offers some conceptual advantage over the more obscure logarithmic scale.
4. The available base may be measured in several ways (actual bicarbonate, standard bicarbonate, Base Excess). Whichever method is used, the base decreases as hydrogen-ion accumulates or bicarbonate is

lost; it increases when hydrogen-ion is lost, or bicarbonate is gained.

5. These laboratory data must be interpreted by the clinician within the framework of the patient's disease and the physiologic adjustments which are taking place.

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As Clay in the Potter's Hand*

A Review of 221 Rhinoplasties

TRENT W. SMITH, M.D.

THE NUANCES of motivation and modality and the surgical satisfactions connected with cosmetic surgery, particularly rhinoplasty, are worthy of review on a semistatistical basis. This review may be of particular interest to members of the medical profession who are prone to think in terms of life-threatening disease only. With such a pattern of thought, medical advisers are tempted to shrug off the patient whose interest lies primarily in the effect and improvement derived from a cosmetic oriented operation.

When one sees the operation entitled Rhinoplasty on the hospital surgical schedule, what does it mean in terms of people and personalities? A review of 221 consecutively operated rhinoplasty cases from my practice during the past two years is presented to consider the status of cosmetic nasal surgery.

As might be expected 72 per cent of the patients were women, the ratio of female to male patients therefore being 3:1. It may come as somewhat of a surprise to the reader that one out of every four nasal plastic operations is performed on a man. As will be shown, this surgery was done primarily for cosmetic improvement (Fig. 1).

One frequently hears the statement relative to a woman considering facial plastic surgery that "she already has a husband; is too old for such vanity" or some similar rationalization. Curiously, one never hears the comment about a husband so inclined; that he already has a wife. The age span of persons having rhinoplasty in this series ranged from 9 years to 65 years. The 9 year old patient's problem was one of iatrogenic origin due to the complete removal of the cartilaginous nasal septum with resulting collapse of the middle one third of the nose and severe saddling. The 65 year old needed an open reduction of a recently fractured nose and elected to get rid of the "family nose" while having the deviated nasal fragments realigned. There was at least one patient for every year in the age range from 13 years through 47 years. There were 14 patients 49 years of age or older.

The anatomical index for the acceptance of younger patients for rhinoplasty depends mainly on two fac-

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tors. These are (1) the relative facial growth of the teenager as compared to the mother, father, or an adult sibling; (2) the maturity of the nasal tip cartilages as demonstrated by their degree of firmness to palpation.²

Of the total number of cases (221) 204 individuals gave as their primary complaint the desire to have the appearance of the nose enhanced. Thus it is observed that 90 per cent wanted cosmetic improvement. It happens that people are inclined to rationalize by using a complaint of nasal stuffiness or other functional nasal disturbance. This invariably is a "games that people play"³ coverup for the fundamental cosmetic need and desire for facial alteration. When asked, "What don't you like about your nose?" the patient answers specifically, "It's too long, too big, has a bump, is crooked etc." The patient has analyzed the facionasal defect and knows exactly, or nearly so, what he hopes can be done. I am very chary of the patient who cannot reasonably pinpoint his defect. Such a patient must be considered very carefully before the surgeon acquiesces to acceptance for surgery. Usually such a patient will be enthusiastic in seeking to have the surgery performed.

Patients having deviated noses associated with severe septal deviation can not be repaired either as to function or cosmesis without doing both a septum reconstruction and rhinoplasty as a combined procedure (Fig. 2). Varying degrees of chin retrusion are occasionally a part of facial mal-development. The combination of chin augmentation with rhinoplasty can produce startlingly successful cosmetic

*Reference 1.
Submitted November 25, 1966.

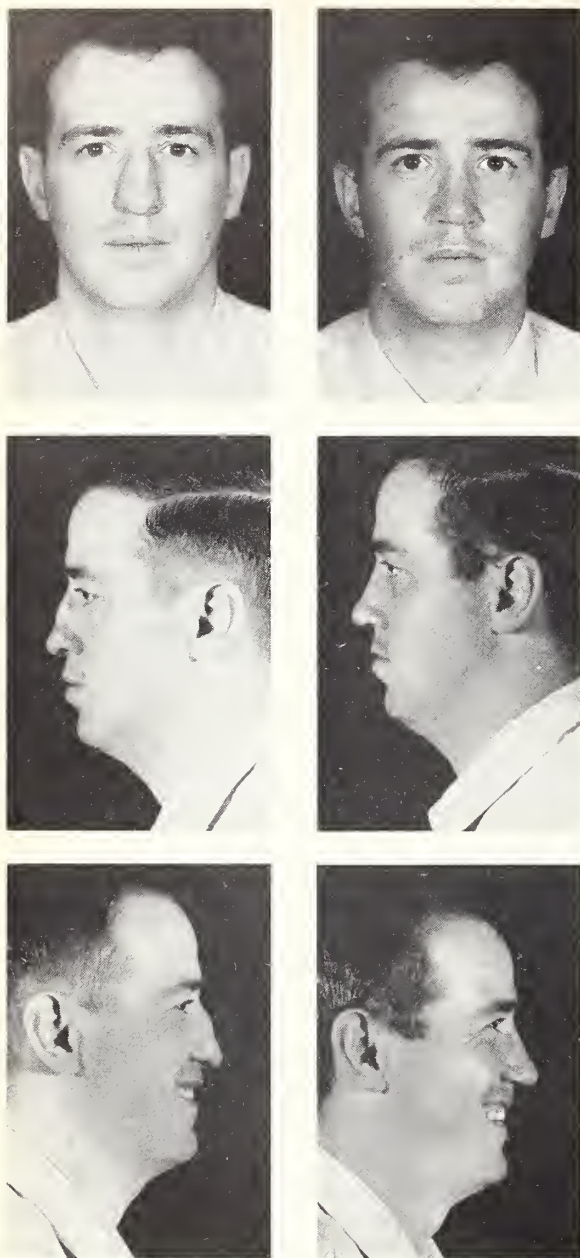


FIG. 1. Preoperative left, postoperative right. Traumatic twisted nose treated by combined rhinoplasty and septum reconstruction.

change by altering the entire facial plane structure. This was done in 17 cases or approximately 8 per cent.

Of the entire series, 32 patients gave a history of recent nasal injury and fracture. By recent I mean nasal injury which had taken place within three weeks prior to the time of examination. Recent nasal injury was a factor in operating upon 14 per cent of the group.

The records indicate my personal surgical satisfaction with the results in 84 per cent of the patients operated. In tabulating this factor, all cases which were of borderline satisfaction to me were considered to be unsatisfactory. Undesirable sequelae of rhino-



FIG. 2. Preoperative left, postoperative right. Deviated, projecting nose with associated micrognathia. Treated by combined rhinoplasty, septoplasty and chin augmentation.

plasty are persistent convexity of the profile; lateral deformity of the nasal vault; concavity of the profile described as saddling; pinched or uneven nostrils; a peculiar fullness or rounding of the distal one fourth of the nose called parrot nose; and other obvious asymmetries. These surgical residuals with the exception of the Polly-beak problem are infrequent in the practice of the experienced cosmetic nasal surgeon. Polly-beak is most frequently a result of improper healing.

Twelve per cent of the cases were revisions of previous rhinoplastic surgery (28 cases). These were revisions of other surgeons' results as well as of my own. One or two patients were being revised for the second time. In the postoperative study of my own cases, there were also 28 patients upon whom I advised revision. Of these patients, many were personally satisfied and pleased. Such patients had no further surgery. A critical appraisal of one's own results is tantamount to good work. In recent years, I have been more inclined to suggest revision even though the patient appeared to be happy with the result.

It had been my belief by surmise that patients arrived at the operating table largely by patient referral or at least by non-physician referral, however figures show 48 per cent of the patients to have been referred



FIG. 3. Preoperative left, postoperative right. Convex profile line treated by rhinoplasty.

by 61 different physicians. Some of these doctors referred more than one patient in the series.

Occupationally 26 per cent of the patients were students of high school through graduate school level. The second largest occupational listing was that of housewife. This is worthy of note relative to remarks about the patient already having a husband and thus having no need for cosmetic improvement of her face. Other ways of life included physicians, dentists, lawyers, factory workers, secretarial people, railroad workers, cocktail waitresses, entertainers, and others.

The height of surgical result in rhinoplasty is not necessarily to produce a beautiful nose per se but to enhance the appearance of the individual face

leaving no indication of surgical correction (Fig. 3). Such a result frequently produces through pure satisfaction in appearance, a lightening of the person's countenance. The evident, pronounced psychologic lift which is so frequently produced appears to be of relatively permanent duration. The personality improvement is marveled at by parents, relatives, and associates. It is the culmination of the rhinoplasty surgeon's training, skill, and experience.

Summary

A clinical review of the cases of 221 persons who requested cosmetic nasal surgery is presented. Comments as to motivation; age for cosmetic nasal surgery; the factors of injury and physical results are made. Stress is placed on the fact that there is surprisingly gratifying and permanent improvement in the patients' general psychic level as well as facial configuration.

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Plastic Surgery of the External Ear

Surgery for protruding ears should aim at creating normal contour of the ear as seen in the lateral view, as well as correcting the protrusion. The otoplastic surgeon should attempt to duplicate natural appearance as nearly as possible. The technique developed is directed toward these goals. Postoperatively, the gradual convexity of the superior crus, without visible incision lines or angulations, is desired. The antihelix proper is subtly prominent and there is a definite groove between the antihelix and helix.

The general physician and the pediatrician are encouraged to be aware of this readily corrective deformity and recommend the procedure, especially where it seems important in the particular individual for his overall well-being and outlook.

Reconstruction of the external ear requires the incorporation of all plastic surgery principles, particularly in the use of both implants and grafts. Combined skin grafts utilizing a variety of both free grafts and grafts bearing their own blood supply must be in the armamentarium. Wherever possible, autogenous implant material is advocated.

In carcinoma, radical excision is essential. For carcinoma of the ear, remove underlying cartilage and bone. If the lesion escapes to the middle ear or mastoid bone, the prognosis is most guarded. If there is any question regarding the margin about the lesion, no principles of cancer surgery should be violated and reconstructive procedures should be disregarded. In most instances, however, some form of primary reconstruction is possible and desirable. — Richard T. Farrior, M. D., Tampa, Florida: *Minnesota Medicine*, 50:839-843, June 1967.

Chemotherapy for the Control of Pain In Inoperable Cancer

A Report of Intra-Arterial Infusion in Four Patients

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INTRODUCTION

CANCER chemotherapy by intra-arterial infusion as described by Sullivan^{1,2} can be used either as an adjunct to surgery or for palliation. This report evaluates the use of this modality for the relief of intractable pain, secondary to incurable malignant tumor, in four patients. These patients were treated at St. Luke's Hospital during the past year. Three of the patients had carcinoma of the head and neck and received methotrexate and the fourth patient had extension of a colon cancer to the pelvis and received 5-fluorouracil.

Biochemical Rationale

Cancer cells are amenable to the effect of anti-metabolites by virtue of their rapid rate of division and consequent rapid synthesis of deoxyribonucleic acid (DNA). The synthesis of DNA in the normal cell, by contrast, is much slower, and this makes the neoplastic cell relatively more susceptible to the effects of the antimetabolite. Folic acid is essential for the synthesis of DNA. One of the biochemical actions of methotrexate is blockage of the folic acid reductase system, and, consequently, the formation of DNA is inhibited, cell reproduction is altered, and death occurs after one or two divisions. The systemic effects of this drug may be controlled by use of its natural metabolic antagonist folic acid. During the infusion, 6 mg. of citrovorum factor is administered intramuscularly every six hours. The infusion program is shown in Table 1.

5-Fluorouracil is a pyrimidine analog, and its incorporation in deoxyuridine has a profound inhibitory action on the biosynthesis of DNA. The ultimate result is similar to that seen with methotrexate. There is no known biological antagonist for this drug.

Studies with these drugs show that an extremely high concentration may be obtained by continuous regional arterial infusion.³ These same concentrations,

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which are considered to be about five times the non-toxic levels, would be lethal to the patient if administered orally or intravenously. Empirically it was noted that 500 mg. of methotrexate, given in divided doses over a 7-10 day period, was usually effective. This seems to correlate with experimental findings that 7 to 10 days are required to label 90 to 100 per cent of the tumor cells with tritiated thymidine.³ These observations form the rationale for the use of intra-arterial infusion of a chemotherapeutic agent over a 7-10 day period.

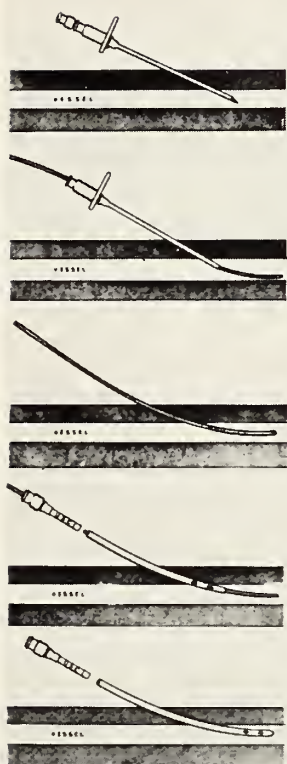
Surgical Technique

For treatment of head and neck cancers, a number 18 polyethylene catheter is inserted, using local anesthesia, into the superficial temporal artery and passed retrograde into the external carotid artery. One per cent Methylene blue, diluted 1:10, or fluorescein is injected into the catheter, which is then adjusted until there is the desired staining distribution of the mouth and tongue without staining of the sclera. If there is any question as to the exact location of the

From the Division of Surgery, Saint Luke's Hospital, Cleveland, Ohio. Submitted November 23, 1966.

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THE PERCUTANEOUS TECHNIQUE INSTRUCTIONS



#1

Local anesthesia is administered and a skin puncture is made with the needle directed at a small angle toward the vessel. Bleeding can be used as a guide to ensure proper location in the vessel. See illustration #1.

#2

Once the needle has been properly located in the vessel remove the needle, leaving the cannula, and insert the flexible spring guide through the cannula into the vessel a short distance. See illustration #2.

#3

Pressure is applied over the site of the puncture and the cannula is withdrawn leaving the spring guide within the lumen of the vessel. See illustration #3.

#4

The preformed catheter is passed over the flexible spring guide directly into the vessel. See illustration #4.

#5

The flexible spring guide is then withdrawn being careful not to withdraw the catheter from the vessel at the same time. See illustration #5.

FIG. 1. The technique for retrograde insertion of a catheter in the femoral artery.

(From U. S. Catheter Company's brochure on Arterial Catheters.)

TABLE 1

METHOTREXATE INFUSION PROGRAM

1. Pre-infusion biopsy
2. Superficial temporal artery catheterization
3. Methotrexate 50 mg. per day
4. Citrovorum factor 6mg. IM q 6h
5. Daily WBC and plate count
6. Discontinue drug WBC < 2000
platelets < 50,000
maculo-papular rash
7. Total infusion dose - 500-700mg.
8. Post-infusion biopsy

catheter, an arteriogram is recommended. The catheter is secured by a technique recommended by Benson et al.⁴ and connected by a three-way stopcock to the pump tubing. Incorporation of the stopcock facilitates injections and manipulation.

Six to eight feet of tubing are attached to allow the patient freedom to move around the bed. A standard infusion pump is used to deliver 1000 cc. of 5 per cent dextrose solution, containing 50 mg. of methotrexate and 10 mg. of heparin, in 24 hours. The solution is arranged in tandem with a second intravenous bottle as a precaution against air embolism. The infusion is continued until the desired dosage is administered, usually 500 mg. over a 7-10 day period, or signs of toxicity develop (Table 1).

In the treatment of pelvic cancer a catheter is inserted in the femoral artery using the Seldinger technique (Fig. 1), and advanced into the iliac artery. Angio-CONRAY® (sodium iohalamate) is injected and placement of the catheter controlled by fluoroscopy. An infusion program employing 10 to 20 mg. of 5-fluorouracil per kilogram per day is continued over a 7-10 day period.

(Continued on Next Page)

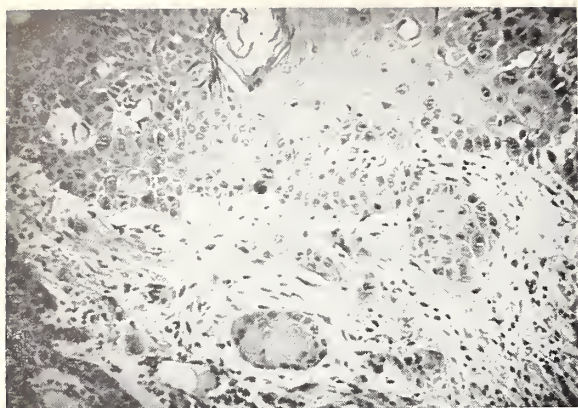


FIG. 2A. Preinfusion biopsy. Well differentiated squamous cell carcinoma.

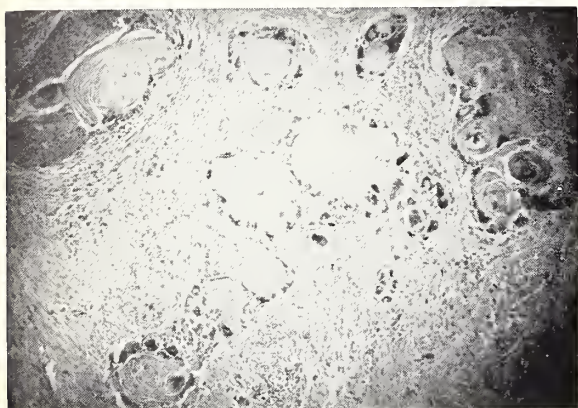


FIG. 2B. Postinfusion biopsy showing fibrosis, giant cells, and mononuclear cells.

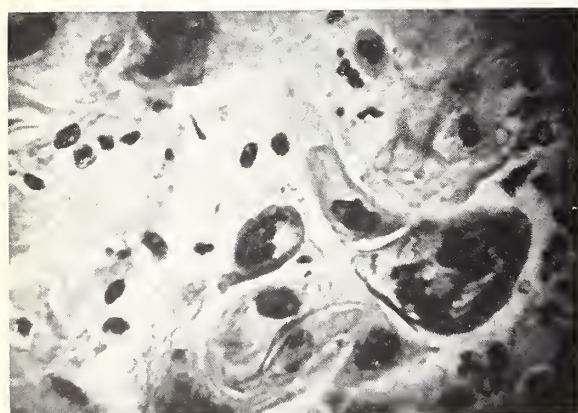


FIG. 3. High power magnification showing nonviable cells with karyorrhexis.

Case Histories

Case 1. A 71 year old white man had a laryngectomy for squamous cell carcinoma in 1960. In 1963, he developed a squamous cell carcinoma involving the left tonsillar fossa and base of the tongue. This was treated by cobalt therapy and a radical neck dissection. In August, 1964, a local recurrence in the tonsillar fossa was treated with cobalt needles. Eleven months later a second recurrence developed, associated with chronic pain. He received 250 mg. of methotrexate by intra-arterial infusion with complete relief of pain. A subsequent biopsy showed only carcinoma in situ.

*Figures 2, 3, and 4 are representative biopsies, not relating to the patients discussed.

Since that time the patient has been free of pain. In April, 1966, a primary squamous cell carcinoma of the right upper lobe was removed. The patient is asymptomatic at the present time.

Case 2. A 53 year old white man presented in August, 1965, with a large mass in the right neck. The mass had been gradually enlarging for about a year and during this time he developed a swollen tongue, difficulty swallowing, and hoarseness. Examination revealed a tumor at the base of the tongue, which was quite extensive. Biopsy revealed squamous cell carcinoma, and the patient was infused arterially with 400 mg. of methotrexate over a 10 day period. There was marked reduction in the swelling of the tongue, and the pain subsided. The patient died two months later, however, from bronchopneumonia.

Case 3. A 69 year old Negro man had a sigmoid colon resection for adenocarcinoma in February, 1964. In October, 1965, an exploratory laparotomy and small bowel resection were performed for recurrent carcinoma with extension to the left pelvic wall. Three months after surgery, the patient became incapacitated by left back and hip pain. In February, 1966, he was infused with 9,100 mg. of 5-fluorouracil, given over a 10 day period. He was discharged in March, 1966, free of pain. Four months later the patient is ambulatory and enjoying his favorite pastime of fishing.

Case 4. An 84 year old white man was found to have a squamous cell carcinoma involving the left tonsillar fossa, tongue, and alveolar ridge in January, 1964. This was treated by cobalt therapy. Ten months later a recurrence was noted in the tongue, and this was treated with cobalt needles. Since that time the patient has had a large persistent ulcer on his tongue associated with intractable pain. In March, 1966, he received 500 mg. of methotrexate via arterial infusion over 10 days with complete relief of pain. Two months later the pain recurred and the patient had a second arterial infusion of 900 mg. of 5-fluorouracil over 10 days. Again complete pain relief was obtained. Three days later, however, the patient died following a myocardial infarct.

Complications

In the present report only two complications were observed. The first patient treated with methotrexate developed a moderately severe bone marrow depression with leukopenia below 2,000. This returned to normal in seven days, when the drug was discontinued. The patient who received 5-fluorouracil developed severe blistering of the skin over the left inguinal region and upper thigh. This healed uneventfully with conservative treatment. Other complications that have been reported are wound infection, extravasation of the drug, maculopapular rash, and cerebrovascular accidents.^{4, 5}

Microscopic Findings

Histological sections of squamous cell carcinoma following infusion with methotrexate show a variety of changes. There is evidence of tumor necrosis with hyalinization and fibrosis (Fig. 2A and B)*. In addition, pyknosis of the nuclei and other intracellular changes including bizarre chromatin arrangements are present (Fig. 3)*. The postinfusion biopsy most often resembles a granulomatous reaction with giant cells, mononuclear cells and fibrosis (Fig. 4A and B)*.

Comments

In the recent literature there have been many reports of the use of intra-arterial infusion as an adjunct to surgery and irradiation.^{1-3, 5, 6} The use of

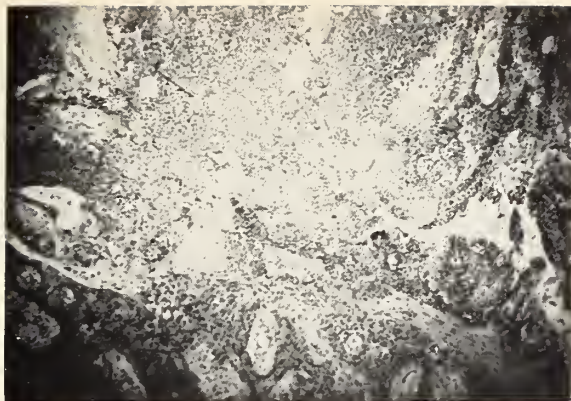


FIG. 4A. Moderately well differentiated squamous cell carcinoma. Preinfusion biopsy.



FIG. 4B. Postinfusion biopsy with moderate fibrosis and karyorrhexis.

this method of therapy for relief of pain is not mentioned extensively.

Benson and associates⁴ employed intra-arterial infusion for the relief of intractable pain secondary to cancer in the head and neck, lumbar spine, pelvis, and lower extremity. They used methotrexate for squamous cell carcinoma and 5-fluorouracil for other types of cancer. Good results were obtained in 70 per cent of the patients.

The limitations of this form of therapy in patients with advanced cancer must be kept in mind. In the palliative patient, treatment should not be instituted with the hope of curing the cancer. The aim should be relief of pain, when ordinary analgesia no longer affords comfort. Awareness of the possible complications is necessary. The use of this method in the terminal patient simply to prolong life is to be condemned. The major objective should be to continue the patient in a pain free, ambulatory status.

Obviously, pain is a difficult complaint to evaluate. The most accurate method of assessing relief of pain is by a reduction in the amount of narcotic required by the patient. All four of these treated patients no longer needed narcotics. Analgesia was obtained with Darvon® or aspirin. Three of the four patients were able to maintain a satisfactory ambulatory status for eleven, five, and two months, respectively. One patient required a second infusion. The fourth patient died in the hospital two months after infusion.

Summary

Four patients with inoperable cancer and intractable pain were treated by intra-arterial infusion during the past year. Two of the four patients are alive and pain free at the present time. A third patient, who required a second infusion two months after the first infusion, died of a myocardial infarct on the day before discharge. The fourth patient died of bronchopneumonia.

This modality certainly may be used successfully for the palliation of intractable pain from cancer. Considerations of this method of pain relief should be made before addicting a patient to narcotics.

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PREVENTION, like cure, is an objective of medicine which depends for its attainment upon a knowledge of disease and its causation and of the methods of recognizing it in individuals. The rest is a matter of administration, propaganda, and ultimately of social and political action. — Alastair Hunter, M. D., F. R. C. P., London, England: *British Medical Journal*, 2:552-557, Sept. 4, 1965.

Wandering Spleen with Torsion Of Pedicle

Report of a Case with Multiple Congenital Anomalies*

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WANDERING spleen with torsion of the pedicle is a medical curiosity. One hundred and twenty cases were reported in the world literature prior to 1943^{1,2,5} with only an incidental case report since. Whipple reviewed 1437 splenopathies in 1945 without including a single case.^{2,4} Forty years experience at the Mayo Clinic from 1904 to 1945 included only two cases.^{2,4} Torsion of the spleen has not been seen in 1157 splenectomies done in our institution over the last 20 years. The most extensive review of the subject was published by Abell¹ in 1933 and consisted of 95 cases. The actual incidence of this condition is unknown.

Diagnosis of wandering spleen is generally made only after the occurrence of an acute surgical complication, the most common of which is torsion of the pedicle.^{1,2,8} Acute torsion of the splenic pedicle results in engorgement of the spleen with hemorrhagic infarction and secondary peritonitis.^{4,8} Preoperative diagnoses are rarely accurate; the most common diagnoses are acute appendicitis with perforation, or torsion of the ovary. A case of wandering spleen with torsion is presented. The presence of a Meckel's diverticulum, intra-abdominal atrophic testicle, and peritonealization of the right colon contribute to its uniqueness.

Case History

A 16-year-old boy was admitted to the Ohio State University Hospital on March 30, 1966, at 1:35 P. M. with an acute abdomen. He was transferred from a juvenile correctional institution. Initial examination demonstrated a slightly retarded and uncooperative patient.

His illness began four days prior to admission. The main complaint was of intermittent, cramping, midepigastria pain. This became progressively severe and more frequent, with localization to the right lower quadrant. The only vomiting was on the day of admission. During this four day period, he had been constipated and had no oral intake other than liquids. He had been aware of two painless, movable lumps in his lower abdomen for nearly a year. He had no history of abdominal trauma. Previous surgery consisted of a left inguinal herniorrhaphy and a left orchiectomy.

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The patient was a well developed, muscular, 16-year-old boy in acute distress. His temperature was 101 F., pulse rate 136, and respiratory rate 30 per minute. Significant findings were limited to the abdomen, which was distended and rigid. Generalized rebound tenderness was present, with particular localization in the right lower quadrant. Bowel sounds were absent. He had no costovertebral angle tenderness, and the psoas sign was negative. A tender cul-de-sac mass was felt on rectal examination. Muscular guarding made it impossible to appreciate any abdominal mass. Roentgenographs of the chest and abdomen were negative.

The white blood cell count was 20,000 with 89 per cent neutrophils. The hematocrit was 47 per cent, and the hemoglobin 16.2 Gm. per 100 ml. The urine had a specific gravity of 1.034 and was negative for acetone. Amylase by the rapid method was normal. Other serum chemistries were normal.

The tentative diagnosis was ruptured appendicitis with peritonitis. Initial treatment consisted of nasogastric decompression, massive doses of penicillin, intramuscular streptomycin, and intravenous fluids. The tachycardia and temperature had resolved by 7:00 P. M., and the patient was taken to the operating room.

Under general anesthesia, a vague lower abdominal mass was palpable. This did not resolve after bladder catheterization. A transverse incision was made in the right lower quadrant. No purulent fluid was demonstrated with incision of the peritoneum. A large, firm, purple mass was seen to occupy the entire pelvis, lying anterior to the bowel and omentum. The incision was extended transversely to the left anterior iliac spine. The mass proved to be an acutely congested spleen with a distended, tense capsule and a twisted pedicle, which was markedly edematous. The splenic artery and vein were readily identified and arose from their normal anatomical positions. The pedicle measured approximately 8 inches and was twisted three times in a clockwise direction (Fig. 1). The pedicle contained no pancreatic tissue. The splenic ligaments were

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absent. The individual vessels were ligated, and the pedicle was incised.

Concomitant abnormalities consisted of a peritonealized right colon with an excessively mobile cecum. An incidental appendectomy was performed and the appendices epiploicae of the cecum and ascending colon were sutured to the right peritoneal gutter. A Merkel's diverticulum 8 cm. from the ileocecal valve was resected. A cryptorchid testicle present in the left iliac fossa was excised.

The postoperative course was uncomplicated. His platelet count rose to 621,000, but there were no thrombotic sequelae.

He was discharged on April 8, 1966.

Pathologic Examination

1. The spleen was large, weighing 608 grams and measuring 15 by 5 by 9 centimeters. The entire specimen was edematous and of dense, cystic consistency. The hilar vessels were swollen and twisted and exhibited thrombosis on



FIG. 1. Torsion of splenic pedicle.

sectioning. The normal trabecular pattern was destroyed. The microscopic diagnosis was intrasplenic hemorrhage and polymorphic infiltration of the hilum, consistent with torsion of the spleen.

2. Meckel's diverticulum consisted of a segment of intestine measuring 3.5 by 2.5 by 1 cm. with normal ileal mucosa.

3. Cryptorchid testicle measured 2.5 by 1.5 by 1.3 cm. and microscopic examination was consistent with an undescended testicle.

4. Appendix was normal.

Discussion

Wandering or floating spleen has been described as the displacement or descent of the spleen from its normal anatomic position. This is differentiated from splenosis, an equally rare condition, consisting of multiple intra-abdominal splenic implants occurring secondary to splenic rupture with autogenous transplantation.⁷ Because of their sessile configuration, the latter rarely undergo torsion.⁵

The pathophysiology of wandering spleen is unknown, though certain congenital and acquired factors have been implicated in its development. Congenital elongation of the splenic pedicle is an inherent requirement of wandering spleen, the length of the pedicle directly limiting its mobility. The normal splenic pedicle is 1½ inches long and has been described up to 12 inches in pathologic specimens.^{1,2} Elongation of the pedicle predisposes to axial rotation. Patients with congenital deformities

of the upper abdominal cavity are likely to have splenoptosis.¹

Splenomegaly is prevalent in wandering spleen,¹⁻⁴ the average weight of the cases reviewed by Abell being 1695 grams. Increased traction per se doesn't entirely explain splenic displacement since some of the largest spleens, as in lipid storage diseases and myelogenous leukemia, though free of adhesions are not displaced.^{1,12} Relaxation of the abdominal musculature and the splenic ligaments are associated factors in many cases. In Abell's series, prolapse of the spleen was most prevalent in multiparous women with inelastic and relaxed abdomens. One or a combination of the forementioned factors are found in the majority of patients with wandering spleens.

Torsion generally occurs in 20 per cent of these people.² Though the exact mechanism is unknown, trauma, excessive exertion, peristalsis, and nonsymmetrical configuration of the organ disturbing its balance have been described.¹ A hemodynamic theory for torsion was advanced by Payr,² in which the differential pressure in the splenic vessels resulted in the coiling of the longer, more distensible veins about the shorter, rigid artery. Torsion occurs most frequently in a clockwise direction and consists of one to three turns with as many as 12 being described.^{1,2}

The symptoms are extremely variable and result generally from traction or pressure upon the involved organ. Acute torsion presents as peritonitis secondary to splenic strangulation and infarction. Treatment is splenectomy. Detorsion and splenopexy are, for obvious reasons, to be avoided.

The etiology of splenoptosis and torsion in this case is unknown. The occurrence of multiple congenital anomalies would make such an explanation plausible for the elongation of the pedicle and the absence of the normal stabilizing ligaments. The cause of torsion without a history of trauma, remains obscure. Hemodynamic torsion may be a plausible explanation.

NOTE: Figure 1 is presented with permission granted by the Ohio Youth Commission, Columbus Juvenile Diagnostic Center, Columbus, Ohio, for release of this photograph.

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Methyl Salicylate Poisoning

Case Report and Discussion of Treatment by Peritoneal Dialysis

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IN THE pediatric age group, accidents and poisonings account for the largest number of deaths, causing more fatalities than the next seven causes combined.¹ Under the age of 5 years, there are about 400 deaths yearly due to poisonings. Because of the universal availability of adult and children's aspirin, cases of salicylate ingestion are common. Not always realized is the fact that Oil of Wintergreen (Methyl Salicylate) is much more toxic than other salicylates. As little as 4 ml. has caused death in children, and there is a 60 per cent mortality in untreated cases of methyl salicylate poisonings.² This paper presents means readily available to manage some of these severe cases.

Case Report

A 3-year-old white boy weighing 35 pounds was brought to the Emergency Room of Akron Children's Hospital, when a "wintergreen" smell was noted to his vomitus. Upon investigation, about 1 ounce from a bottle of oil of wintergreen was missing, and it could not be determined how much the patient had ingested. This had probably been taken several hours previously.

When first seen, the patient was lethargic, flushed, and hyperpneic. His vital signs included a heart rate of 136 per minute, a respiratory rate of 40 per minute, blood pressure 104/70, and temperature 98.6 F. A salicylate level done immediately showed a value of 118 mg/100 ml. His hemoglobin was 15.3 Gm. with white blood cell count 15,800 showing a slight predominance of segmented forms. The blood urea nitrogen was 15 mg/100 ml. An ampule of sodium bicarbonate (50 cc. of solution containing 44.6 mEq.) was given immediately intravenously followed by 500 ml. of 5 per cent dextrose in water with 20 mEq. of sodium chloride at 100 ml/hour. Another ampule of sodium bicarbonate was added to the intravenous bottle. Ten to 20 mEq. of potassium chloride were added to each intravenous bottle following this, once good urinary function had been established.

Because of the markedly elevated salicylate level and because the patient was becoming unresponsive, it was decided to begin intermittent peritoneal dialysis immediately. The patient was catheterized and the trochar inserted under local anesthesia into the right lower quadrant of the abdomen. The polyethylene catheter was then guided into the right lateral gutter area. One thousand ml. of Peridial® 1½-D (Cutter) warmed to body temperature was given each of two hours, followed then by increments of 750 ml. every one to one and a half hours. This solution contains 140 mEq/liter of sodium, 4 mEq/liter of calcium, 1.5 mEq/liter of magnesium, 102 mEq/liter of chloride, 43 mEq/liter of bicarbonate and 1.5 grams of dextrose per liter. Fifty mg. of tetracycline and 10 mg. of heparin were added to each lot. The fluid was allowed to run in and distend the abdomen rapidly and then was drained off by gravity as quickly as possible. One hundred sixty-seven mg/100 ml. of salicylate was removed in all in the dialysis fluid with the average being 12 to 14 mg/100 ml. in each lot.

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It was necessary to monitor carefully the patient's serum electrolyte values often and to adjust the intravenous fluids accordingly. Potassium in particular must be followed closely since the dialysis fluid is potassium free. Please see Table 1. At the end of 24 hours, the patient appeared much improved and the salicylate level had fallen to 55 mg/100 ml. Dialysis was discontinued at this time and the patient was continued on intravenous fluids and given clear liquids orally. By 48 hours after treatment was begun, the patient appeared clinically recovered. He was discharged after several more uneventful days of observation.

Discussion

Symptoms observed early after salicylate ingestion may be irritability and vomiting but these are usually followed in several hours by hyperpnea and lethargy. An excitatory phase with delirium may develop and progress to seizures and coma and death. Initially, transient respiratory alkalosis may be present but by the time patient is seen, this has usually progressed to a metabolic acidosis. Treatment depends on the amount and severity of the poisoning and must be individualized to the patient's particular electrolyte problem.

There were 2326 cases of aspirin ingestion treated at Akron Children's Hospital during the years 1960 through 1965. A review of hospital records shows 542 cases admitted in the past 10 years because of this problem. Five patients died.

In mild cases, gastric lavage or the production of vomiting by use of ipecac is adequate therapy. Methyl salicylate delays the emptying time of the stomach so that emesis or lavage may be effective up to four to six hours after ingestion. In those cases where a greater amount has been ingested or an undue delay between the time of ingestion and the onset of treatment has occurred, more must be done. Intravenous fluids with alkalinization of the urine results in the cure of most of these. In the most severe

TABLE 1

Time (hours)	Salicylate Level (mg/100 ml)	Sodium (mg/100 ml)	Potassium (mg/100 ml)	Chloride (mg/100 ml)	Carbon Dioxide (Vol %)	Ph
Admission	118	146	2.9	102		7.350
4	115	143	3.3	98		
8	109	138	3.3	98		
12	77				24.8	7.610
16	69	141	2.6	98	23.7	7.605
20	67	142	2.8	99	26.3	7.515
24	55	140	2.7	100	28.2	7.565
28	48	143	3.1	101	22.0	7.58
34	28	138	3.5	108	21	7.50
40			3.5		21	7.44
46			4.6		19	7.44
52			4.1		20	7.395

cases, three means of therapy remain: exchange transfusion, hemodialysis, and peritoneal dialysis.

Methods of Treatment

Exchange transfusions are excellent in the infant but as the size and weight of the patient increases, this method becomes less and less efficient. It is generally ineffective to remove toxic substances distributed throughout the total body water³ and too much blood is needed to significantly lower toxic values.

Hemodialysis is the most effective method available for the treatment of poisonings. James et al⁴ in experimental salicylate intoxication in dogs were able to remove 50 per cent of the dose in a four hour period using hemodialysis. This is, however, technically difficult in the small child. A single coil may use 400 ml. of blood and with fluctuations in capacity, sudden changes in the child's blood volume or body fluids may occur and cause serious problems. If a trained team is available, this is probably the method of choice. In many hospitals, however, such teams are not on hand. In these circumstances, peritoneal dialysis offers an uncomplicated, safe and effective method of managing severe poisonings.

Comment

Besides salicylate poisonings,^{5,6} intermittent peritoneal dialysis has been used for salt poisoning,⁷ boric acid poisoning,⁸ meprobamate poisoning,⁹ intractable congestive heart failure,¹⁰ amphetamine poisoning,¹¹ pentobarbital intoxication,¹² isoniazid intoxication,¹³ renal failure,¹⁴ etc. Disposable pre-sterilized units are available, which allow the physician to set up treatment immediately at the patient's bedside. Commercial solutions in various strengths can be used depending on the size of the patient and the condition under treatment. This system may be set up quickly and be functioning in one-half to one hour, a time factor which may be valuable in the toxic patient. Hemodialysis, especially in relatively inexperienced hands, may take many hours longer to be set into effect.

The chief problem encountered in peritoneal dialysis is poor inflow or outflow of the dialysis fluid. This occurs because of clinging of the omentum or intestines to the catheter, because of clots occurring

in the tubing, or because of blockage with tiny pieces of tissue or omental fat. Blood-tinged fluid is seen occasionally but frank bleeding is ordinarily not encountered. It is important not to make the original incision too large so that leakage and fluid loss about the catheter does not occur. Careful records of the amount of fluid inserted and returned must be kept and the patient's vital signs and electrolyte concentrations must be regularly evaluated and any variations treated accordingly. As mentioned previously, hypokalemia, in particular, may develop rapidly since the dialysis fluid as prepared is potassium free.

With new equipment and improved methods, peritonitis is a rare complication. Maxwell et al¹⁵ had no infections in 76 cases treated in this manner. Closed system technics with new sterile tubings being used for each infusion are helpful in preventing these problems. It is also recommended that broad spectrum antibiotics be added to the dialysis fluid and that the procedure be limited to 36 hours' duration.

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A Baedeker for Fat-Controlled Diets

VII. Dietary Components Other Than Fat

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A NUTRITIOUS diet is assured when foods for fat-controlled diets are chosen and prepared as discussed in previous pages. The daily food pattern (Table 1) provides generous amounts of all essential foods: (1) meats, (2) dairy products, (3) fruits and vegetables, (4) breads and cereals. Two servings of lean meat, fish or poultry supply protein, iron and various B-complex vitamins. Two cups of skim milk contribute protein, calcium and B-complex vitamins not present in substantial amounts in other foods. Four servings of whole grain or enriched breads and cereals provide additional iron and B-complex vitamins, and four servings of fruits and vegetables, adequate amounts of vitamins A and C. Dark yellow and dark green vegetables are especially high in vitamin A; citrus fruits are high in vitamin C. Limitation of eggs is not detrimental because the same nutrients are provided by other common foods.

In the vegetable-oil food pattern, fortified margarines provide additional vitamin A and also vitamin D. The oils themselves are rich in α -tocopherol. Even though α -tocopherol requirements increase with the intake of polyunsaturated fatty acids, there is no evidence that a deficiency will develop. Plasma α -tocopherol levels in persons who have been on diets high in unsaturated fatty acids for four years were found to be similar to those of persons eating a customary diet.⁹

Other therapeutic diets may be modified in fat while still retaining their essential characteristics. Foods low in sodium content can be adapted to fat-controlled diets; vegetable oils do not contain sodium; unsalted polyunsaturated margarines are available. Both sodium restriction and fat alteration require food preparation from the proper raw ingredients.

Recent concern over the wisdom of using large quantities of whole milk and cream in peptic ulcer regimens has led to development of fat-controlled ulcer diets. Palatable skim milk and corn oil "creams"

have been used successfully.¹⁰ Other foods suitable for ulcer diets can be made compatible with fat-controlled diets.

Diabetic diets with modified fat are being developed by the American Dietetic Association and the American Diabetes Association. The well-known exchange lists are still used, but the choice of foods within them is changed to conform to the principles of fat-controlled diets. For example, skim milk replaces whole milk, lean cuts of meat are used and polyunsaturated margarines replace the usual spreads.

Thus far, fat has been the main nutrient discussed in relation to blood lipids. However, their levels are also affected by other dietary factors including carbohydrate, protein, minerals, vitamins, pectin and fiber. These factors are of little practical importance except for carbohydrate, which may raise triglyceride levels. In hyperglyceridemia and mixed hyperlipemia, elevated triglyceride levels are controlled better with the vegetable-oil food pattern which contains moderate amounts of carbohydrate, than with the low-fat (high carbohydrate) diet. Although sensitivity to carbohydrate varies greatly among individuals, hyperglyceridemic patients as a group are the most sensitive. Simple sugar is especially hyperlipemic. In certain patients, substitution of complex carbohydrate or starches for sucrose without fat alteration has been found sufficient for blood lipid reduction.¹¹

The various fat-controlled diets which have been discussed in these articles have been used successfully in "anti-coronary" public health programs and in experimental projects both in the United States and abroad. A report of the results of a five year study in Norway with a group of patients having had previous myocardial infarctions was published recently.¹² Significantly ($p < .02$) fewer recurrences of heart attacks developed in the group of patients under 60 years of age who were following a vegetable oil diet than in the group remaining on their customary diet. There was a high degree of correlation between the mean plasma cholesterol concentration maintained during the period of observation and myocardial reinfarction.

This Baedeker describes briefly the way to extend promising treatment to more coronary prone individ-

The Heart Page is a periodic feature of *The Journal* containing brief, practical comments on subjects of immediate importance to practicing physicians. The comments are solicited by the Professional Education Committee of the Ohio State Heart Association.—ED.

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uals. A simple paper electrophoretic technique¹ for determining abnormal blood lipid patterns will soon be in common use. Practical food patterns which reduce blood lipid levels have been developed, and proper foods are available in the supermarkets. Physicians are now in a position to use fat-controlled diets, individually tailored by the dietitian, as a weapon in their fight against atherosclerosis.

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DATA-PHONES, one of man's newest information transmitting devices, are being used in a University of Cincinnati Medical Center search for vital information about one of man's oldest concerns, the ailing heart. From patients so critically ill they cannot leave their beds, the Data-Phones send findings to the University's Cardiac Laboratory in Cincinnati General Hospital. There, the researchers are trying to improve current electrocardiographic diagnostic criteria for detecting individual cardiac chamber enlargement in both congenital and acquired heart disease. Telephone officials consider this special use of the Data-Phone service unique among approximately 10 medical centers which have similar equipment.

Dr. Ralph C. Scott, University of Cincinnati associate professor of medicine and the principal investigator, is comparing the accuracy of the EKG to the orthogonal EKG and to the vector cardiogram. He comments that "the vector cardiogram is a tool many cardiologists can use in the hospital and the office. It is helpful in looking for various conditions that do not show up so well in the EKG."

General Hospital patients cooperating in the study are taken to the laboratory for the three-way recordings. But when patients are critically ill, the laboratory goes to their bedside, via Data-Sets. This Bell System Service, installed by the Cincinnati and Suburban Bell Telephone Co., enables information to be sent as electrical signals over regular telephone wires, either simultaneously with voice or as an alternate to voice. This is how it works: A technician wheels the equipment cart to the bedside in any one of the hospital's four patient areas which are fitted with multi-conductor outlets. She plugs in the system. This includes three preamplifiers and three transmitting analog Data-Sets. The leads are attached to the patient's chest. The technician lifts the handset, automatically ringing the Cardiac Laboratory several buildings away. She identifies the patient. Then the heart takes over. With each heart beat, three separate signals are sent at once over a three-channel private line wire. The signals flow along telephone lines in shielded cables running from the patient areas across the hospital complex to the laboratory. Three Data-Sets receive the signals and record them. Since April 1965 more than 1000 patients have been studied.

Two more steps complete the research. From the 7040 IBM computer in the University Computer Services at the College of Medicine, Dr. Scott obtains more complete and accurate analysis of the information. The last step gives final evidence of the project's progress toward more effective detection of heart disease: Detailed dissection of hearts of persons who have had EKGs within three months of their death. The department of pathology has studied more than 400 of these hearts at autopsies. They provide an irrefutable check on the accuracy of the diagnosis made while the person lived. — University of Cincinnati Medical Center: NEWS RELEASE, June 21, 1967.

A Clinicopathological Conference

From The Ohio State University Hospital, Columbus, Ohio

Edited Under the Auspices of the Ohio Society of Pathologists

PAUL N. JOLLY, M.D., *President*

PRESENTATION OF CASE

THIS white male grocery owner, aged 58, entered Ohio State University Hospital with a chief complaint of abdominal pain of six months' duration and jaundice of one week's duration. He had been in relatively good health following a heart attack seven years prior to admission until one year before hospitalization, when he had pneumonia manifested by fever, chest pain and cough, lasting for two weeks. Shortly after this episode he had what he termed "a gallbladder attack" characterized by abdominal pain, nausea and vomiting which woke him at night and was relieved by an injection given by his family physician. There was no associated jaundice or other gastrointestinal symptoms at that time. Six months prior to hospitalization the patient had a gripping pain in the upper abdominal area bilaterally which was increased in severity by the intake of food and was relieved by "pain pills." During one physical examination his physician found the patient's liver enlarged and prescribed "large red pills." The patient then had a gradual weight loss until the time of his admission, dropping from 205 to 185 lbs. An associated distaste for cigarettes developed whereas prior to this he had smoked two packs a day. He had a mild persistent nonproductive cough and became aware that the girth of his abdomen was progressively enlarging. Two months prior to his admission, an application for a food-handler's license required a chest x-ray, which revealed a "spot" at the base of the right lung the size of a silver dollar.

Three weeks prior to hospitalization he became aware of dark-colored urine and light stools and felt somewhat weak but had no fever. For the two weeks prior to admission he vomited approximately once a day but had no hematemesis. Ten days prior to admission he was told that his skin looked yellow and during this period of time he had at least two black stools. There was no past history of diarrhea or constipation, injections, transfusions or fever. The patient had had no alcoholic intake in the past four years and had taken only an occasional drink prior to that time. The patient's left leg had been amputated many

Presented by

- Robert L. Wall, M.D., Columbus, and
 - Emmerich von Haam, M.D., Columbus.
- Edited by Dr. von Haam.

years ago following trauma. The family history was not contributory.

Physical Examination

The physical examination revealed an obese icteric white man who appeared his stated age. The temperature was 98.6 F., the pulse 88, the respirations 26, and the blood pressure 140/70. The sclerae showed moderate icterus. There were some expiratory wheezes throughout both lung bases. The heart was normal in size. The first heart sound at the apex was prominent, and there was a questionable protodiastolic gallop rhythm. The abdomen was protuberant and soft with a somewhat nodular liver palpable 5 fingerbreadths below the right costal margin. The spleen was palpable 2 fingerbreadths below the left costal margin and was firm and nontender. There was no venous distention or spider angiomas over the abdomen, and a fluid wave was not elicited. Rectal examination revealed no abnormalities. There was a trace of ankle edema. The left leg had been amputated below the knee.

Laboratory Data

At the time of admission the white blood cell count (WBC) was 11,297 with 89 per cent neutrophils, 11 per cent lymphocytes; hemoglobin 12.8 Gm.; hematocrit 43 per cent; reticulocyte count 4.6 per cent; blood urea nitrogen (BUN) 13 mg./100 ml.; blood sugar 113 mg./100 ml.; prothrombin time 14.6 per cent of normal. Urinalysis showed 40 mg. of protein per 100 ml. and 6-8 WBC per high-power field. The urine was positive for bile and negative for urobilinogen. The serum glutamic oxalacetic transaminase (SGOT) level was 106 units, the glutamic pyruvic transaminase (SGPT) 37 units; total protein 7.2 Gm./100 ml. (albumin 4.2 Gm., globulin

3.0 Gm.); alkaline phosphatase 90.6 units; direct reacting bilirubin 8.6 mg. /100 ml., total bilirubin 12.6 mg.; cephalin flocculation 1 plus; thymol turbidity 25 units. The SGOT on a second determination had risen to 120 units. Gastric analysis showed 31° of free hydrochloric acid at the end of one hour. Gastric washings showed Papanicolaou class II with nests of atypical cells. The serum electrolytes, the serologic tests for syphilis, and the creatinine were within normal limits.

Pulmonary function studies showed a vital capacity of 104 per cent, timed vital capacity at 3 seconds of 86.5 per cent, and maximum breathing capacity of 64 per cent of normal. The electrocardiogram showed myocardial changes, some of which could have been due to digitalis.

The chest x-ray showed widening of the right superior mediastinum with a nodular outline thought most likely due to lymph node enlargement. The right hilum was enlarged by a mass or lymph nodes. The heart was within normal limits. An upper gastrointestinal series revealed deformity of the antrum of the stomach, particularly on the lesser curvature, presumably inflammatory in nature, and an otherwise normal esophagus, stomach and duodenum. Barium enema showed diverticulosis of the colon with a probable mass in the superior pole of the right kidney. Follow-up chest x-ray on the eighth day of hospitalization showed a fairly extensive pleural effusion on the right which had not been present previously.

Hospital Course

The patient was afebrile throughout his hospitalization. He was treated initially with Mercuhydrin®, and having lost 5 lbs. he was digitalized on the third hospital day. Oral vitamin K was administered with no significant change in the prothrombin level, but with parenteral vitamin K his prothrombin time rose to 68 per cent of normal. On the third hospital day his jaundice appeared to be receding. Skin tests for tuberculosis and histoplasmosis were negative. On the sixth day the patient had right pleuritic chest pain and a friction rub was heard. A chest x-ray at this time showed pleural effusion. Gradually increasing shortness of breath and wheezing developed as well as increasing icterus. Further diagnostic studies were suspended. The dyspnea gradually progressed, and he stopped breathing on the seventh hospital day.

CLINICAL DISCUSSION

DR. WALL: Essentially, this is a 58-year-old man who had had an episode seven years ago thought to be a heart attack and six years later had pneumonia with characteristic fever, chest pain, and cough which lasted about two weeks. Subsequent to this he had a gallbladder attack with pain at night relieved by some kind of medication, and whether this was another heart attack or whether the first pain was a gallbladder attack we really can't tell from the in-

formation at hand. It does focus my attention on his heart and gallbladder.

His real problems began apparently six months prior to admission when bilateral upper abdominal pain developed, which was not too well localized and which increased in intensity until his hospitalization. His doctor found hepatomegaly and gave him some 'red pills.' I don't know whether these were diuretic but at least he started to lose weight and lost about 20 lbs. as his upper abdominal pain progressed.

Loss of Taste for Cigarettes

He then developed a cough and gradual abdominal swelling and lost his appetite for cigarettes. We quite commonly associate this loss of appetite for cigarettes with hepatic disease or biliary disease. Evidence of biliary obstruction then developed. He started to vomit and had two episodes of tarry stools suggesting that he had an ulcerated lesion somewhere in his gut. If we combined this with biliary obstruction, we would place his lesions somewhere near the end of the stomach or duodenum. He had had nothing to suggest a viral type of hepatitis. So we are left with a man who had progressive pain in the upper abdomen for six months with weight loss and cough, who then developed jaundice, biliary obstruction, and G.I. bleeding.

When he was admitted to the hospital he was described as obese—despite his weight loss. His vital signs were not too abnormal. He had some wheezes at his lung bases and a questionable gallop rhythm although his heart was thought to be of normal size. His protuberant abdomen was apparently due to hepatosplenomegaly and not to ascites. He had minor pitting edema of the remaining lower extremity. He had no distention of his abdominal veins.

Review of Laboratory Data

The laboratory tests showed a mild leukocytosis with no striking change in the differential count, a very mild anemia, and a low prothrombin level, which improved after injections of vitamin K. He also had some protein and some white cells in his urine, which was strongly positive for bile. His elevated bilirubin and alkaline phosphatase levels again suggested biliary obstruction. A gastric analysis discovered some unusual cells which were suspicious but not really diagnostic for cancer, but free hydrochloric acid was present. The rest of the liver function tests didn't seem to be too bad, suggesting again that he had biliary obstruction rather than hepatoparenchymal disease. If he did have intrinsic hepatic disease it would have to be focal, such as a metastatic or primary malignant tumor. His pulmonary functions were not too bad except for his maximal breathing capacity, and here I think we must take into consideration that he was a pretty sick man with lots of abdominal disease. Surely his plain vital capacity

and timed vital capacity were not too bad. His electrocardiogram showed some nonspecific changes. Thus he remains a patient whose laboratory work didn't tell us too much other than what we had already suspected clinically. I wonder if we could go over the x-rays?

Review of X-Ray Studies

DR. DUNBAR: As noted, he had enlargement of the peritracheal nodes on the right, and there was thought to be a hilar mass also on the right side. The left hilum too is prominent. I don't think this is also due to lymph nodes but represents possibly a big pulmonary artery, and at some time he may have had a thrombus or an embolus in this left lower lobe. It certainly is not a quite normal left hilum. These other chest films show that he developed right-sided effusion and patchy infiltrates of his right base. I think this is most likely a pneumonitis. The upper kidney mass is seen best on the film of the barium enema. I don't think there is evidence of a pancreatic mass. The abnormalities along the lesser curvature of the stomach are not impressive; there is really no evidence of stomach or duodenal disease. So our major positive findings are peritracheal masses, hilar masses, and an upper right abdominal mass, and I think that this must be a neoplasm of some kind.

From the x-rays alone, the question that arose in my mind was whether this was not a bronchogenic carcinoma, since it is not unusual for a bronchogenic carcinoma to spread into the abdomen, particularly toward the liver. I am inclined to think that this would be an unusual carcinoma of the kidney, but it would be not at all unusual to have a bronchogenic carcinoma with mediastinal and abdominal spread. Perhaps I should say that a widespread lymphoma could also produce this.

DR. WALL: Did you see the previously described solitary lesion?

DR. DUNBAR: No. I don't know where it was or what it was.

DR. VON HAAM: Is the lung involvement bilateral or unilateral?

DR. DUNBAR: This is one of our problems. I have decided that it is probably unilateral. I feel that his right hilum is big and his right peritracheal nodes are big, and that he has a mass in the right upper quadrant of the abdomen. If I could convince myself that these were all lymph nodes, then I would suggest lymphoma, but since I can't convince myself of that I still prefer a bronchogenic carcinoma.

DR. WALL: Radiographically, he doesn't have tremendous splenomegaly, does he?

DR. DUNBAR: No, it is certainly not big.

Clinical Discussion Resumed

DR. WALL: So we have learned now that our patient had unilateral or bilateral lung disease. We are impressed that he didn't show much evidence of

ascites, and we are less impressed with his splenomegaly than we were at the bedside and are more impressed with the right kidney mass.

Well, what happened to this man? They tried to diurese him a bit and he lost 5 lbs. They then went through the vitamin K procedure which we have already mentioned, and on the third day his jaundice cleared somewhat. There is no chemical support to this and it is a clinical observation which might very well be true. We don't know of any change in his stools at this time to suggest that he had a partial or intermittent obstruction of his biliary tract. But this is an interesting clinical observation and makes you wonder about some ball-valve mechanism in his obstructed biliary system. It is true that tumors can do this too, either from sloughing some tumor or even forming a new pathway, and surely stones can do it, we know. But again, we did not see any radiopaque stones and we don't see anything to suggest a big gallbladder. He had skin tests, which were negative. Then on the sixth hospital day something catastrophic happened. He suddenly developed right pleuritic chest pain, a friction rub, and evidence of rapidly accumulating fluid with increasing dyspnea and sudden death. This would suggest a pulmonary embolus, a tumor invasion of some large vessels with thrombosis, or even tumor emboli.

Certainly a Malignant Tumor

So we are dealing with a patient who most likely had a progression of growth of some form of tumor. I can't think of any non-neoplastic disease that could present all these symptoms. In thinking of tumors that could develop in this area, we teach that when anybody has progressive, continuous pain in the epigastrium for which you cannot find a reason he probably has pancreatic carcinoma. Not finding any enlargement of the C-loop, we surely would assume that it was in the body or tail of the pancreas, and we would therefore expect late biliary obstruction.

In thinking of other tumors that we could consider, we should think of hepatoma, which can be painful. But hepatoma is a rare tumor unless we have associated portal cirrhosis, or nutritional cirrhosis, for which we actually have no evidence. Gallbladder carcinomas are notoriously difficult ones to diagnose because they can spread even from small foci and metastasize early.

A third type of neoplasm has already been mentioned by the radiologist, and we cannot ignore bronchogenic carcinoma if we believe that this is a unilateral chest lesion, although I am still awfully suspicious of the left hilum. Is it possible that a man can have extensive bronchogenic carcinoma and show his major manifestations in his abdomen? Of course it is, and early metastases are not unusual in bronchogenic, and I know of no way to rule it out. Obviously we ought to think of lymphoma. However, my original diagnosis of unilateral chest disease and

the complete absence of lymphadenopathy anywhere else in his body make this diagnosis rather unlikely. Another possibility in a man who has already had evidence of bleeding in his gut is carcinoma of the stomach. The fact against such a diagnosis is the presence of plenty of free acid in the stomach. The significance of the Pap class II cells is not very great.

There is really very little to support the diagnosis of renal carcinoma, and we also do not have any further evaluation of the kidneys, such as intravenous or retrograde pyelography. When we see a big tumor on top of a kidney we obviously have to think of kidney tumors as well as adrenal tumors. But again I know of nothing to support or exclude such a diagnosis. I think we could mention a lot of other tumors, but I think the ones I have mentioned are the most likely ones, and I would think we would be remiss in our teaching function not to suggest that anybody who has progressive upper abdominal pain followed by obstructive jaundice would have any other than a primary gallbladder or pancreatic tumor, and that is my diagnosis.

General Clinical Discussion

DR. COLTMAN: Why do you think he died, Dr. Wall?

DR. WALL: We suspect that he had some pulmonary catastrophe and one bet, I think, is pulmonary artery thrombosis, or metastatic disease involving the same vessels. Certainly once it began it was catastrophic. Apparently he died within 24 hours of the time that he developed the pleuritic chest rub, and obviously if he had pleurisy he could have had an underlying pneumonia, but from the description of the patient up until that time it sounds unlikely that he could have died that rapidly with pneumonia.

DR. COLTMAN: Dr. Carter, what do you think of this renal lesion that you see here? Can you make anything out of it?

DR. CARTER: If you didn't have the history that makes you wonder whether he didn't have a tumor, I think you could make a very good case for this being a benign cyst sitting on the upper pole.

DR. COLTMAN: Dr. Pratt, what do you think of this chest x-ray?

DR. PRATT: I am not too impressed with the lesion on the left side. I think it is right-sided bronchogenic carcinoma.

DR. COLTMAN: Mr. Monteleone, your diagnosis was in variance with Dr. Wall and with the diagnosis of other medical students. Would you care to comment on this?

MR. MONTELEONE: I thought he had lymphoma because I thought he had lymph nodes in his superior mediastinum but something above the kidney. I wasn't entirely sure that this was connected with the kidney, and I thought perhaps he had some type of

lymphoma blocking his duodenum and giving him an intermittent type of jaundice.

DR. COLTMAN: I think that by and large the feeling of the group here is that this patient had malignant disease and the majority thought that it was intra-abdominal malignancy of some sort. Dr. von Haam, was this right?

CLINICAL DIAGNOSIS

1. Primary carcinoma of gallbladder or pancreas with metastasis to right kidney and mediastinum.
2. Possibly bronchogenic carcinoma with metastasis to mediastinal lymph nodes, kidney, and liver.
3. Obstructive jaundice.

PATHOLOGIC DIAGNOSIS

1. Hodgkin's sarcoma, generalized.
2. Bilateral bronchopneumonia (neoplastic type).
3. Intrahepatic obstructive jaundice.

DISCUSSION OF PATHOLOGY

DR. VON HAAM: The autopsy showed that the patient suffered from a widespread lymphoma which involved all mediastinal and mesenteric lymph nodes, heart, lungs, liver, spleen, stomach, small intestine, pancreas, kidneys, thyroid, and bone marrow. Of special interest was the spleen, which weighed 700 grams, and the enlargement of the retroperitoneal lymph nodes, which represented the mass seen in the right kidney region. The tumor tissue was soft, hemorrhagic, and had the typical gross appearance of a rapidly growing lymphoma. The microscopic examination of the tumor showed Hodgkin's disease with neoplastic proliferation of the endothelial cells, producing the so-called Hodgkin's sarcoma. It was this malignant transition which was apparent in most of the metastatic tumors in the various organs, while the primary Hodgkin's disease with its eosinophils, Sternberg cells, and fibrosis was present only in the mesenteric and mediastinal lymph nodes.

Microscopic examination of the lungs showed a pneumonia-like picture with multifocal tumor infiltrates in the alveoli resembling the so-called neoplastic pneumonia. The gastrointestinal hemorrhage originated from the tumor infiltrates of the wall of the stomach and small intestine. His "late jaundice" was due to intrahepatic obstruction of many bile ducts by the tumor metastases in the liver.

In conclusion then, we have an individual who died from a rapidly advancing Hodgkin's disease without the usual clinical signs (fever, palpable lymph nodes). It probably started in either the mediastinal or mesenteric lymph nodes and very early became sarcomatous. The neoplastic process never involved

a peripheral gland which could have been palpated and biopsied. Of course an exploratory laparotomy would have given the diagnosis immediately and the patient could have been subjected to the specific therapy.

General Discussion

DR. COLTMAN: Dr. Wall, would this patient have responded to therapy in your opinion?

DR. WALL: Yes, as far as treatment goes, he might have done real well for a while. In retrospect, I think the thing that killed this patient was the fact that he

had bellyache for six months and they didn't do anything much about it and when he finally got jaundiced there are certain restrictions on what one could do. I think the most direct approach would have been to have Dr. Klassen biopsy the superior mediastinum of the right side, even extrapleurally, and get a prompt diagnosis.

DR. VON HAAM: Another most interesting thing is that the patient had no evidence of either heart or gallbladder disease. He had a perfectly normal gallbladder without a single stone, and he had perfectly normal coronary vessels.

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NEWS AND *Organization Section*

Ohioans Take Leading Roles in the AMA Atlantic City Convention

THE American Medical Association House of Delegates set two records in sessions during the 116th Annual Convention of the AMA in Atlantic City, June 18-22. The House roll call showed high attendance at all sessions, and 100 per cent attendance—242 delegates out of 242—for the Tuesday and Wednesday sessions. The other record was the handling of 151 items of business, including 123 resolutions from state associations.

Ohio delegates were as busy as any at the meeting. Eleven Ohio resolutions were introduced, and followed through the various steps of committee hearings and House action.

Here is how Ohio resolutions fared:

- The House approved the Ohio resolution which states that, "It is proper for the physician to establish the fee which he charges to any patient for the professional service rendered, with recognition of the fact that a duly constituted *County Medical Society* committee of his peers may appropriately review and pass upon the equity and justice of his charge."

The resolution amends a policy statement adopted at the 1966 Clinical Convention entitled "Policies Regarding Payment for Professional Medical Services."

- The House approved an Ohio resolution calling for the AMA to evaluate operation and effectiveness of voluntary health planning groups to provide guidance and impetus to physician involvement in such planning.

- On the Ohio resolution calling for payment of usual, customary, and reasonable fees for services to military dependents, the House accepted a motion by Dr. John H. Budd, chairman of the Ohio delegation, to refer the matter to the AMA Board of Trustees.

Dr. Budd's motion came after presentation of the reference committee report which contained an erroneous statement that usual, customary, and reasonable fees already were in effect in the dependents' care program.

- The House referred to the Board of Trustees an Ohio resolution calling for appointment of an ad hoc committee "to prepare and to report for House approval at the Clinical Session 1967 recommendations for practical restructuring of the AMA table of organization and authority which will assure effective leadership operating within policies established by this House, enhance AMA responsiveness to the edicts of its membership, and unify presentation of its policies to Congress and the public."

The action to refer to the Board was taken after the reference committee recommended that the resolution not be adopted.

- An Ohio resolution calling for more meaningful representation on the AMA Council on Medical Education by physicians practicing in nonuniversity-affiliated hospitals was rejected by the House.

- The House approved an Ohio resolution calling for amendment of the AMA Constitution and Bylaws to provide that late resolutions may be introduced with approval of two-thirds of the delegates rather than the presently required unanimous consent. The Council on Constitution and Bylaws was directed to prepare the amendment for action by the House.

- The House approved an Ohio resolution calling for earlier submission of reports and resolutions to enable delegates to study the material prior to opening of the conventions.

- An Ohio resolution calling for AMA opposition to the American Nurses' Association's "Position Paper" opposing diploma schools of nursing in favor

of baccalaureate programs, along with similar resolutions, was replaced by a substitute resolution. The substitute resolution's final resolve states, "That the American Medical Association take appropriate action in consultation with professional nurses' associations and the American Hospital Association to encourage increasing enrollment in diploma schools and at the same time improve educational standards."

- Ohio was one of two states to submit resolutions regarding smoking and health, and the physician's responsibility in this field. The House adopted a substitute resolution reading as follows:

"Whereas, the AMA recognized and continues to recognize the deleterious effects of tobacco on human health, and urges physicians to engage more actively in intensive education programs regarding smoking and health; therefore be it

"Resolved, That the AMA reaffirm its policy regarding tobacco and health, and vigorously continue its measures for corrective action."

- The House amended and approved an Ohio resolution calling for all local medical society leaders to support, contribute to, and participate actively in local Medical Political Action Committee activities.

- An Ohio resolution urged the AMA to take steps toward making 25 per cent physician representation on hospital governing boards a requirement for accreditation by the Joint Commission on Accreditation of Hospitals.

The House adopted a substitute resolution based on the Ohio and other resolutions concluding as follows:

"Resolved, That the JCAH be requested to encourage through its publications and in its surveys, the acceptance, wherever possible, of physicians elected or appointed by the medical staff to the Board of Trustees with full voting rights as the most effective form of liaison between the medical staff and hospital governing authorities; and be it further

"Resolved, That this House of Delegates direct the Board of Trustees to instruct the AMA Commissioners to the JCAH to seek the full cooperation of the JCAH in implementing this principle."

As indicated in the foregoing summary, Ohio fared well with its resolutions. House action on the total number of resolutions shows that of the 123 state resolutions, 27 were adopted, 25 were amended and adopted, 22 were combined with one or more others into substitute resolutions, 8 were replaced by substitute resolutions, and 14 were not adopted.

Dr. Hudson's Remarks

At Sunday's opening session, the House heard outgoing President Charles L. Hudson, Cleveland, urge physicians of the United States to "take the initiative and apply local solutions to local problems" in order to "persuade people that the proper function of gov-

ernment is to confine its activities to the support of private enterprise rather than to act as a competitor." Dr. Hudson stressed that it remains a continuing charge of physicians "to seek out and meet any discovered needs for health care" and observed that "One of the greatest challenges facing the medical profession now and in the immediate future . . . is the organization of community health care."

At his Tuesday evening inauguration as the Association's 122nd President, Dr. Milford O. Rouse, Dallas, Tex., followed a similar theme in pointing out that "The federal government is making its moves into areas where, to its own satisfaction at least, it is able to demonstrate unfulfilled needs for health care or health care planning. If we are alert to our responsibilities for filling all of the apparent vacuums in communitywide health programs, we can eliminate areas which may seem to demand government involvement.

"Leadership will be provided," Dr. Rouse said, "in these areas of community planning and the provision of community health services for all people. The only undefined factor is the source of that leadership. If it is not the physicians of the community, it will be government in one of its many forms."

President Rouse listed some of the many problems now facing the medical profession, asserting however that "this is a time not for despair, but for a clear recognition of crises that are approaching; a time not for anger and frustration, but for unswerving determination to face our problems and solve them; a time not for philosophy alone, but for action to make our philosophy a reality."

In this report to the House Thursday, President Rouse elaborated on that theme and listed what he considers to be some of the solutions to the problems facing medicine. Among the items he included were more unity within the medical profession; greater interprofessional harmony with all other elements of health care; better communications between physicians and their societies at every level, and between physicians and the public; increased participation by physicians in the deliberations and programs of the medical associations; more activity by physicians in the political and civic affairs of their communities; and the development of citizen interest in matters of over-all health.

"As we have done in the past," the President told the House, "we shall gladly respond to requests from government or from any other source for advice on health matters. . . . But, as in the past, we shall insist that we be approached in good faith, with the assurance that our freedom of judgment and freedom of action will be preserved.

"Our future," he concluded, "will not be determined by those who oppose us, but by our own willingness to accept the responsibilities which are naturally ours."



A reception in honor of Mrs. Karl F. Ritter, Incoming President of the Woman's Auxiliary to the AMA, was sponsored by the Ohio State Medical Association and the Ohio Auxiliary in the Shelburne Hotel, Atlantic City.

In the receiving line, from left, are: Mrs. Christopher Colombi, chairman on arrangements for the reception; Dr. Robert E. Howard, OSMa President; Mrs. Howard; Mrs. James N. Wychgel, Ohio Auxiliary Past President; Mrs. Ritter; Dr. Karl F. Ritter; Dr. Laurence C. Meredith, OSMa Immediate Past President; Mrs. Meredith; and Mrs. J. Paul Sauvageot, President of the Woman's Auxiliary to OSMa.

Other Actions of the House

One subject that has generated interest not only in the profession but among legislatures and the public is therapeutic abortion. The House updated and liberalized the AMA's policy in this regard.

In regard to generic prescribing, a resolution combining several state resolutions was adopted by the House, asserting "that the AMA again reaffirm its policy that physicians should be free to use either the generic or the brand names in prescribing drugs for their patients; and encourage physicians to supplement medical judgments with cost considerations in making this choice."

Members' Disability Insurance Program

The House adopted the report of the Reference Committee on this subject, and referred to the Board a number of resolutions pertaining to it.

The Committee's report, as adopted, recommended that the House authorize the Board to make every effort to continue the AMA Members Group Disability Insurance Program with the same premium-benefit structure. It also recommended the following guidelines to aid the Board in negotiating and executing the necessary contracts and in the future operation of the program:

1. The contract should provide ample assurance that disability claimants will be treated equitably and justly.
2. The carrier should guarantee benefits and

premiums for a period of at least five years in order to assure the stability of the program.

3. Promotional literature should be approved in advance by the Board or its designee. All measures within the bounds of dignity and ethics should be utilized to promote the program.

4. A continuous ongoing review of the entire program should be maintained. The insureds and other members should be made aware that such a review may reveal in the future the necessity for a revision of the program at the end of the five-year period.

5. Information regarding the operation of the program, its financial aspects and the processing of claims should be available to the Board for review at any time.

6. An AMA Disability Insurance Review Committee should be continued and should provide a mechanism for claims review.

Ohio Delegation

The following Ohio delegates were present at the meeting:

Dr. John H. Budd, Cleveland, chairman of the delegation; Dr. Theodore L. Light, Dayton, also OSMa President-Elect; Dr. Carl A. Lincke, Carrollton; Dr. Richard L. Meiling, Columbus; Dr. Frederick P. Osgood, Toledo; Dr. George W. Petznick, Cleveland; Dr. Charles A. Sebastian, Cincinnati; and Dr. Edmond K. Yantes, Wilmington.

Dr. Walter J. Zeiter, Cleveland, was delegate from the AMA Section on Physical Medicine.

Ohio alternate delegates present were the following: Dr. Philip B. Hardyman, Columbus; Dr. Harry K. Hines, Cincinnati; Dr. Robert S. Martin, Zanesville; Dr. Horatio T. Pease, Wadsworth; Dr. Frank Rawling, Toledo; Dr. P. John Robeck, Cleveland; also OSMA Councilor of the Fifth District; and Dr. Robert N. Smith, Toledo, also OSMA Councilor of the Fourth District.

Dr. Donald Glover, Cleveland, was an alternate delegate from the AMA Section on General Surgery.

Dr. Petznick served on the House of Delegates Reference Committee on Amendments to the Constitution and Bylaws.

Dr. Budd was chairman of House Reference Committee C.

Among key Ohioans who attended sessions of the House of Delegates were the following:

Dr. Robert E. Howard, President of the Ohio State Medical Association; Dr. Lawrence C. Meredith, OSMA Immediate Past President; and Dr. Edwin R. Westbrook, member of The OSMA Council. Numerous other Ohioans were present to participate in the program and to attend various meetings and functions.

Accompanying the Ohio delegation were Hart F. Page, OSMA Executive Secretary; Charles W. Edgar, OSMA Director of Public Relations; Herbert E. Gilen, Assistant Director of Public Relations; and W.

Michael Traphagen, and Jerry J. Campbell, Administrative Assistants.

Frank W. Van Holte, administrative vice-president of Ohio Medical Indemnity, was in Atlantic City and discussed the AMA Disability Insurance program with members of the Ohio delegation.

Elections

Dr. Dwight L. Wilbur, San Francisco, Calif., was named President-Elect. Dr. Wilbur has been a member of the Board of Trustees since 1963. He will serve in his new capacity for one year and will be installed as the Association's 123rd President at its annual convention in his home city in June, 1968.

Dr. Malcolm E. Phelps, El Reno, Okla., who has been field director of the Volunteer Physicians for Vietnam program, was elected Vice-President of the Association.

Dr. Walter C. Bornemeier, Chicago, was re-elected Speaker of the House, and Dr. Russell B. Roth, Erie, Pa., was re-elected Vice-Speaker of the House.

Four Trustees were elected to succeed themselves: Dr. Wesley W. Hall, Reno, Nev.; Dr. Irvin E. Hendryson, Denver, Colo.; Dr. Alvin J. Ingram, Memphis, Tenn.; and Dr. Robert C. Long, Louisville, Ky.

Dr. Edward R. Annis, Miami, Fla., was elected to complete the term on the Board of Trustees vacated by the death of Dr. Homer L. Pearson, Miami, Fla.; and Dr. Burt L. Davis, Palo Alto, Calif., was elected to complete the term as Trustee vacated by the resignation from the Board of President-Elect Wilbur.

Woman's Auxiliary Highlights...

Ohio's Mrs. Carl F. Ritter Installed as President of the Auxiliary to AMA at National Convention in Atlantic City

By MRS. S. L. MELTZER, Portsmouth
Chairman, Publicity Committee

IT could have been a movie set. There was the elegant room, and the wide outside balcony that faced the long stretch of beach onto which white-capped breakers disintegrated rhythmically. There were the attractive, beautifully-gowned women—the impeccably-attired doctor-husbands—the table of hors d'oeuvres that would have defied any cuisine anywhere—the many other “goodies” and ingredients for a special occasion. And reigning over it all, there was the gracious “queen” of the festivities—Mrs. Carl F. Ritter, newly-installed President of the Woman's Auxiliary to the American Medical Association.

This was, to stop being lyrical for the moment, the reception at the Hotel Shelburne in Atlantic City tendered in Mrs. Ritter's honor Wednesday evening, June 21 by the Ohio State Medical Association and its Woman's Auxiliary. Mrs. Christopher Colombi, a past state president and former National Board member, headed the committee on arrangements in her usual remarkably effective manner.

It was a proud occasion, of course, for Ohioans, this forty-fourth Annual Convention. Earlier that day, Gerby Ritter had been installed as National Auxiliary President. Her poise, her quiet dignity, her tremendous competence and marked dedication equip

her well for the heavy responsibilities which will be hers this year of 1967-68. Among Ohio members, she holds a record for service on the National level. It is a privilege for us, the Auxiliary to the Ohio State Medical Association, to tender our heartfelt congratulations. Our pride and our delight know no bounds.

Welcoming the guests on the receiving line—in addition but naturally to the delightful Dr. and Mrs. Karl F. Ritter—were Dr. and Mrs. Lawrence Meredith, (he is immediate Past OSMA President); Dr. and Mrs. Robert Howard (Dr. Howard is the current OSMA President); Mrs. Christopher Colombi; Mrs. Paul Sauvageot, Ohio Auxiliary President; and Mrs. James N. Wychgel, immediate past Auxiliary President. Four Ohio members served as hostesses: Mrs. John Dickie, Mrs. Herbert F. Van Epps, Mrs. Malachi W. Sloan, II, and Mrs. Russell L. Wiessinger. Your reporter cannot leave the reception scene without this "aside": The very talented Dr. John Budd of Cleveland spotted the piano and in short order that became the focal point, as it were! For suddenly and wonderfully, voices were raised in song and there was a delightful songfest. So tantalizing was the nostalgic music that even those who couldn't sing—well, *too* well!—couldn't refrain from joining in. (Wonder how many had trouble speaking the next morning!)

Mrs. John Dickie and Mrs. Herbert Van Epps will be serving on the National level this year: Mrs. Dickie as North Central Regional Vice-President and Mrs. Van Epps as North Central Regional AMA-ERF chairman. Happily also we tender congratulations to those two long-time Auxiliary members (and past state presidents).

Of course, no National Convention would be adequately reported without mention of the traditional Ohio Breakfast (would you believe it—a full complement of delegates and alternates at 7:30 in the morning??). This year's excellent breakfast was tendered by Ohio's outgoing President, the indefatigable Ruth Wychgel. At each plate was Ohio's red carnation arranged as a small corsage which we wore throughout the convention as our badge of honor! There is something about this annual breakfast that defies words. Certainly there is a togetherness, a strong sense of camaraderie, an air of festivity. Here's to many, many more of them . . .

The induction of the 1967-68 National officers was conducted by Mrs. Paul C. Craig, a past National President, who pointed out that an installation is a ceremony linking past and future. She paid tribute to all those who had served these many years and declared that the work of the Auxiliary is "built on the fundamental principle of man's need for woman's services." Mrs. Craig closed the eloquent ceremony with a short, meaningful prayer, and then,



Ohio's Mrs. Karl F. Ritter, Incoming President of the Auxiliary to AMA, and Dr. Milford O. Rouse, Incoming AMA President, exchange greetings at the Atlantic City meeting.



These gracious hostesses for the reception honoring Mrs. Ritter in Atlantic City are officers or former officers of the Woman's Auxiliary to OSMA. From left, are Mrs. Malachi W. Sloan, President-Elect; Mrs. Russell L. Wiessinger, Treasurer; Mrs. Herbert Van Epps, and Mrs. John Dickey, Past Presidents.

in a special tribute to Dr. Ritter, added movingly: "Thank you, Dr. Ritter, for marrying Gerby"!

Mrs. Ritter's inaugural address was a pertinent reaffirmation of everything the Auxiliary stands for and everything the Auxiliary hopes for. Whenever Gerby Ritter talks, it's what is in her voice as well as what lies in her words that makes what she has to say doubly significant. She thanked Dr. Milford Rouse, the new AMA President, for coming to witness her installation (this is the first time we know of that an AMA President has so honored an incoming Auxiliary President). Mrs. Ritter admitted to a "veritable smorgasbord of emotions." She spoke of the privilege of working with outstanding groups of leaders at every Auxiliary level and emphasized that this is an era of shifting changes and upheaval.

"AMA-ERF, Health Careers and Legislation have been emphasized in the past," she said, "and must continue to be emphasized in the future . . . membership must be foremost too in our thinking—an increase of 10,000 in that membership is a big order but not an impossible one." She emphasized the need for continued stress on health education and on public relations. "Almost unbelievable accomplishments have been made, and can continue to be made," the new President said further, "when there is ingenuity, hard work and careful planning . . . begin with a sense of loyalty, of dedication, of cooperation . . . be sure to have a sense of humor . . . the job is big but the Auxiliary is big too . . ." Mrs. Ritter's closing words were a wonderful quote from Benjamin Franklin: "Well done is better than well said." She was given a standing ovation.

Dr. L. W. Like, representing the Lima and Allen County Academy of Medicine, presented Mrs. Ritter with a gift. And Ruth Wychgel, on behalf of the Ohio Auxiliary, presented her with a rose-colored "tote bag" crammed full of special gifts, expressing the hope that "everything will come up all roses for you." And last—but certainly not least—Gerby's own Allen County Auxiliary honored her with a special presentation, asking one of its past presidents, Mrs. Thomas Roess, to do the honors.

Dr. Robert Howard, OSMA President, was also on hand for the installation. He said that "we need more Indians than chiefs" and went on to praise Auxiliary efforts on behalf of the medical profession. "If we didn't have you girls working for us, we wouldn't have as many friends in Congress as we do," he commented. (Thanks, Dr. Howard, so very much for calling *all* of us "girls"! It made our day!)

Choice Tid-Bits

Still in Atlantic City . . . Mrs. Asher Yaguda of New Jersey was the presiding officer as National President for this 44th Annual Convention. Miss Margaret Wolfe, executive secretary of National

Auxiliary, was honored with a gift and citation on her twenty-fifth anniversary in that capacity. She was also made an honorary member. The luncheon on Monday, June 19, was heralded as "Toast to a Rose" and honored the leaders of National Women's Volunteer Organizations. Guest speaker was Anne R. Somers, research associate, Industrial Relations Section, Princeton University. The luncheon on Tuesday, June 20, honored National's past presidents. Our own Dr. Charles L. Hudson, 1966-67 AMA President, spoke on "The Women—Bless 'Em"! (And he did bless us—most eloquently and gratefully). "It's not easy to be a physician's wife," he conceded.

Mrs. Yaguda, on behalf of the Auxiliary, presented to Dr. James Z. Appel, President of AMA-ERF, a check in the amount of—hold your seats!—\$384,649.48! How about that? This was not only the largest amount ever given by the Auxiliary, but it recorded the largest increase ever made in one fiscal Auxiliary year—an increase of \$39,000. Add to that total AMA-ERF figure, one of over \$600,000 that was raised this past year by auxiliaries for loans and scholarships in our Health Careers project and you will come up with an almost incredible fact: That our doctors' wives groups throughout these United States just this past year alone came up with virtually ONE MILLION DOLLARS in contributions for medical education in one form or another as well as for research. If any one of you has ever entertained any doubts about the value of Auxiliary work, read those figures I've just given you over and over and over!

Back to AMA-ERF

This year, awards were given for the largest contributions in each of six divisions: from 1 to 500 membership—Wyoming; from 501 to 1,000—Maryland; 1,001 to 1,500—West Virginia; 1,501 to 2,000—Tennessee; 2,001 to 3,000—Indiana; over 3,000—California. Yes, Ohio was nosed out again by the state whose membership of 9,358 made possible a contribution of \$48,233.74 as compared with our membership of 5,600 and a contribution of \$38,691.85. However, Tuscarawas County again came up with a National award—which gave us a place in the spotlight anyhow! The State of New Jersey donated \$1,000 to AMA-ERF in Mrs. Yaguda's honor.

There were some 357 delegates at Convention. Alternates and members brought the total registration up to 1,052. Mrs. C. C. Long of Arkansas is National President-Elect.

Looking at it all from every possible angle, it was a most successful and satisfying 44th National Convention . . . And to you, Gerby Ritter, (and I know I speak for every Ohio Auxiliary member!) every good and warm wish for a truly rewarding year.

Activities of County Societies . . .

BELMONT

The Belmont County Medical Society held its regular monthly meeting on June 15. Program speaker for the occasion was Dr. Robert N. Lewis, of St. Clairsville, whose topic was, "Malaria in Returning Vietnam Veterans." Dr. Lewis was one of a number of Belmont County natives who have addressed the Society during the 1966-1967 season.

After the July and August vacation months, the Society will begin its fall meetings in September with Dr. Arthur G. James, of Columbus, as speaker. Other scheduled speakers are Dr. James R. Hodge, Akron, November meeting, and Dr. Nicholas J. Teteris, Columbus, November meeting.

KNOX

Dr. Raymond S. Lord was installed as president of the Knox County Medical Society at a dinner meeting on June 7 at the Alcove.

Dr. Robert Sooy was named president-elect, and Dr. James R. McCann, secretary-treasurer. Dr. James McLarnan was named delegate, and Dr. Henry Lapp, alternate. Dr. Gordon Pumphrey was elected to the board of censors.

The scientific part of the program was conducted by Dr. Roy Secrest who spoke on the subject, "Injuries to the Spine."

MONTGOMERY

As a result of the recent elections, Dr. James G. Tye was named president-elect of the Montgomery County Medical Society, to take office on January 1, 1968.

On the same date, Dr. Peter A. Granson will succeed as president, following the current president, Dr. W. J. Lewis in that office. Dr. Tye will assume the presidency on January 1, 1969.

The annual meeting of the Society was held at the Wright Patterson Air Force Base Officers' Club.

Dr. Arnold P. Gold, assistant professor at Columbia University College of Physicians and Surgeons, was guest lecturer at Children's Hospital in Columbus. He is a graduate of the University of Lausanne, Switzerland.

Dr. Norman O. Rothermich, Columbus, was presented a distinguished service award by the Arthritis Foundation at its 19th annual meeting in New York. He is one of the founders of the Central Ohio Chapter of the Arthritis Foundation and served as the first chairman of its medical and scientific committee.

Columbus Physician Is Reappointed To Ohio Public Health Council

Announcement recently was made from Governor James A. Rhodes' office that Dr. Phillip T. Knies, Columbus physician, has been reappointed to the Public Health Council for an additional seven-year term, effective July 1. Dr. Knies has served three terms on the council, having been first appointed in 1946.

The Public Health Council has important functions in regard to promulgation of regulations pertaining to public health under the Ohio Code; conducting hearings in regard to making and amending regula-



Phillip T. Knies, M.D.

tions; designating the number and functions of divisions and bureaus of the Ohio Department of Health; making recommendations and advising the director of health on matters which come under jurisdiction of the department, etc. The work load of the council is indicated by the number of meetings on its schedule. Required by law to hold quarterly sessions, it recently has been meeting monthly.

Dr. Knies is a practicing physician in Columbus, specializing in internal medicine and certified by the American Board of Internal Medicine. Among his professional activities, he is on the faculty of the Ohio State University College of Medicine. His military record includes active duty during World War II, and the rank of colonel in the Army Medical Corps.

Other members of the Public Health Council are: Chairman, David H. Ross, M.D., administrator of the Jewish Hospital Association, Cincinnati; Von H. Klepinger, businessman of West Alexandria; Richard V. Brunner, D.D.S., Portsmouth; J. Howard Holmes, M.D., Toledo; Ralph K. Ramsayer, M.D., Canton; and J. F. Mear, Martins Ferry pharmacist. William H. Veigel, chief of the Division of Vital Statistics, Ohio Department of Health, is secretary to the council.

Outstanding Scientific Exhibits At Annual Meeting Awarded

ONE OF THE DRAWING CARDS at the 1967 OSMA Annual Meeting in Columbus, May 15-19 was the Scientific Exhibit, with its companion Health Education Exhibit. Continuing a policy recommended by the Committee on Scientific Work and approved by The Council, awards were authorized for certain exhibits designated as outstanding by the judging committee. A summary of exhibits selected to receive awards was printed in the July issue of *The Journal*, with four additional exhibits designated for honorable mention. Two student exhibits played unique roles in the presentations and their sponsors were awarded certificates of merit. Following are brief descriptions of two of the outstanding exhibits, with the addition of one of the student exhibits. Additional write-ups on outstanding exhibits will be published in forthcoming issues of *The Journal*.

The Exhibit on OB Amniography Awarded in Research Field

Gold Award winner in the field of original investigation at the 1967 OSMA Annual Meeting was the exhibit entitled "Amniography in Obstetrics," sponsored by Dr. Clarence R. McLain, Jr., Department of Obstetrics and Gynecology, Ohio State University College of Medicine. (Dr. McLain has since accepted an appointment in Cincinnati.)

Following is a brief description of the exhibit and the background of material it contained.

Amniography consists of opacifying the amniotic fluid in the pregnant uterus with a suitable contrast medium in order to delineate the uterine cavity and to study certain aspects of maternal and fetal physiology.

Since 1960 the exhibitor has used the procedure for obstetrical diagnosis and to study fetal physiology in over 200 patients. The procedure is not difficult and can be performed in any hospital with standard radiology equipment.

Prior to the 1967 annual meeting of the OSMA the amniography exhibit was presented in part at the Annual Clinical Meeting of the American College of Obstetricians and Gynecologists in 1962 and received the second place award. In November, 1962 the exhibit received a certificate of merit award at the Clinical Meeting of the Radiological Society of North America.

The enlarged exhibit as presented at the recent OSMA meeting described the method and contrast medium used.

Amniograms were demonstrated illustrating the value of the procedure in the diagnosis of placenta previa, hydramnios, congenital abnormalities of the uterus and fetus, fetal death in utero, premature separation of the placenta, hydatidiform mole and hydrops of the fetus. The procedure not only establishes an accurate diagnosis of fetal death in utero

and hydatidiform mole but will frequently terminate a pregnancy with these complications.

A major portion of the exhibit was a study of the rate of fetal swallowing and gastrointestinal motility at different periods of gestation in normal and abnormal pregnancies.

By obtaining serial amniograms at different time intervals, the contrast material can be followed through the fetal stomach, small bowel, and colon. The changes in function of the gastrointestinal tract of the fetus in chronic fetal distress was demonstrated by amniograms in patients with abnormal pregnancies such as erythroblastosis, toxemia, hydramnios, diabetes, chronic renal disease, essential hypertension, and sickle cell anemia.

The data demonstrated in the exhibit is currently being used for further investigation into evaluating chronic fetal distress in high risk obstetrical patients.

The following reprints are available by writing to Clarence R. McLain, M.D., Department of Obstetrics and Gynecology, University of Cincinnati College of Medicine, Cincinnati, Ohio.

1. Amniography Studies of The Gastrointestinal Motility of The Human Fetus, *American Journal of Obstetrics and Gynecology*, Vol. 86, No. 8, August, 1963.

2. Amniography, A Versatile Diagnostic Procedure in Obstetrics, *Obstetrics and Gynecology*, Vol. 23, No. 1, January, 1964.

3. Amniography for Diagnosis and Management of Fetal Death in Utero, *Obstetrics and Gynecology*, Vol. 26, No. 2, August, 1965.

Honorable Mention to Exhibit on Colitis-Regional Enteritis

The Exhibit, "A Comparison of Chronic Ulcerative Colitis and Regional Enteritis of the Colon," was designated for Honorable Mention in the teaching field by the judging committee. The exhibit was

Two of the Outstanding Scientific Exhibits



Dr. Clarence R. McLain, left, receives a plaque designating his exhibit "Amniography in Obstetrics" the Gold Award winner in the field of original investigation. Dr. Samuel Saslaw, chairman of the OSMA Committee on Scientific Work, makes the presentation.



Dr. R. Allan Hart, Fellow in Gastroenterology at the Cleveland Clinic, who helped man the exhibit designated for Honorable Mention in the teaching field, is congratulated by Dr. Lawrence C. Meredith, 1966-1967 President of OSMA. The exhibit was entitled, "A Comparison of Chronic Ulcerative Colitis and Regional Enteritis of the Colon."

PATHOLOGICAL FEATURES

Pathological Features	Chronic Ulcerative Colitis	Regional Enteritis
Location of inflammation	Mucosal	Transmural
Granulomas	None	Frequent
Fissuring	None	Frequent
Fibrosis	Submucosal	Transmural, irregular
Submucosal lymphedema	None	Present ("cobblestoning")
Serositis	Not present	Always present
Enlarged mesenteric lymph nodes	Infrequent	Always present
Inflammatory masses	None	Frequent
Strictures	None	Frequent
Abdominal wall and internal fistulas	None	Frequent
Shortening of the colon	Frequent	Very Rare
Extensive small bowel involvement	Never	May occur
Segmental distribution of disease	None	Frequent
Mucosal ulceration	Diffuse-no normal mucosa	Normal mucosa between ulcers
Cobblestoning of mucosa	None	Frequent
Pseudopolyps	Frequent	Rare
Crypt abscesses	Frequent	May occur

sponsored by Drs. Richard G. Farmer, William A. Hawk, Rupert B. Turnbull, Jr., and Frank L. Weakley, Departments of Gastroenterology, Pathology, and Surgery, Cleveland Clinic Foundation, Cleveland.

Following is a brief description of the subject matter contained in the exhibit, written by a member of the team.

Chronic ulcerative colitis and regional enteritis of the colon (Crohn's disease) are the two principal idiopathic inflammatory and ulcerative disorders of the colon. Because both are ulcerative and inflammatory there has been a tendency to consider these disorders as interesting variations of the same disease. The purpose of this exhibit is to delineate some of the important clinical and pathologic features. This seems best done by comparison and contrast. The exhibit is based on an analysis of 151 operated cases from the Cleveland Clinic.

Clinical Features

1. An atypical sigmoidoscopic appearance is more common in regional enteritis. The mucosa usually shows irregularly distributed serpiginous ulcers that are separated by intervening areas of normal mucosa in counterdistinction to the diffuse and uniformly involved mucosa of chronic ulcerative colitis.

2. Perianal fistulae are more common in regional enteritis and may antedate the colonic disease.

3. Recurrent ileitis after colectomy and multiple operations are more frequent in regional enteritis. The incidence of this complication is no greater in patients who have the ileum involved at the time of original colectomy than in those who do not.

4. Roentgenograms of the colon in regional enteritis may show irregular, disproportionate, seg-

mental involvement with deep fissures and strictures commonly present.

5. Carcinoma was found in 12% of patients operated for ulcerative colitis and in no patient with a diagnosis of regional enteritis of the colon.

6. Rectal bleeding is more frequent in ulcerative colitis.

7. Toxic dilatation of the colon may occur in both conditions.

Pathological features are shown in the accompanying table.

These clinical and pathologic features provide a basis for the separation of these two entities and at least 95 per cent of the cases. The importance of making the distinction is three fold. First, chronic ulcerative colitis has an appreciable risk of the development of cancer, second, therapy is different for each of these disorders, and third, though our knowledge of the etiology is scant, separation will allow study and perhaps understanding.

Certificate of Merit Goes to High School Student Exhibit

The Ohio State Medical Association's judging team paid special tribute to Jeffrey Hill, student of Whetstone High School in Columbus, for his exhibit entitled "Cancer — Serological Diagnosis?" The exhibit was awarded a Certificate of Merit.

An innovation of this year's exhibit was a display of Hill's and another student's exhibit which will be described later. A judging team for the Educational Foundation of the Academy of Medicine of Columbus and Franklin County awarded the two



Whetstone High School Student Jeffrey Hill explains his exhibit and research to two members of the OSMA Council, Dr. Lawrence C. Meredith, 1966-1967 President (center), and Dr. Theodore L. Light, since named President-Elect of the Association.

student exhibits top honors as previous entries in the Sixth Annual Central Ohio Regional Science Fair, sponsored by Otterbein College at Westerville. The student exhibits were placed in the OSMA Scientific Exhibit on recommendation of the Columbus Academy team.

Jeffrey Hill described his exhibit and its background in the following brief sketch.

My research was basically a preliminary exploration into the possibility of a serological diagnosis of cancer. During my five month quest for information and possible detection techniques, I talked to professionals in many fields. My quest has led to medical doctors, a doctor of biochemistry, lab technicians, an expert on electrophoresis and experts on blood filtration, besides my readings. After acquiring some basic knowledge from these sources, I spent three months developing my method and instrumentation, and conducting some preliminary research before I exhibited.

When I exhibited my work and results were described in a seventeen page booklet. This booklet was accompanied by a set of graphs that further explained my project. The exhibit itself showed some of my apparatus (a fraction-collector, which I designed and built, and a Sephadex column).

To the best of my knowledge, my research is ori-

ginal, although I have been informed that a group on the West coast may be starting something of a similar nature. Although I have received significant results, I have proven nothing. On the strength of my results, though, I plan to continue with a more sophisticated set-up in the future.

If I am able to isolate a blood protein that is a consistent indication of cancer, as I hope, the implications and possibilities will be unlimited.

Federal Solid Wastes Program Grants Shared by 32 Enrolled States

Seven additional States have enrolled in a national campaign for planning safe and sanitary disposal of refuse and other solid wastes on a statewide basis with the assistance of grants from the Solid Wastes Program of the Public Health Service's National Center for Urban and Industrial Health.

Award of the grants brought to 32 the number of states participating in the campaign with Solid Wastes Program funds covering up to 50 per cent of the cost of developing plans for meeting State waste disposal needs. Ohio is one of the 32 states participating in the program, grants to which so far amount to about \$1,490,000.

Eleventh District Recognition Dinner



Photo Courtesy of Chronicle-Telegram, Elyria

From left are Professor and Mrs. William C. Craig, Dr. Lawrence C. Meredith, Dr. James C. Stephens, Mrs. Meredith, and Mrs. Stephens (Jeanne Stephens, M. D.).

A recognition dinner for Dr. and Mrs. Lawrence C. Meredith was held at the Oberlin Inn, Oberlin, on Tuesday evening, June 13th. Sponsored by William R. Schultz, M. D., Councilor for the Eleventh District, and other District officers, the dinner was held to honor Dr. Meredith for his outstanding service as President of the Ohio State Medical Association during the past year.

Host Society for the occasion was Lorain County Medical Society, and all the Medical Societies within the 11th District were well represented in the large number that attended.

The evening commenced with a social hour for members and wives followed by dinner. James T. Stephens, M. D., Oberlin physician, served as Master of Ceremonies, and A. Burney Huff, M. D., of Wooster, delegate to the State organization from Wayne County Medical Society, introduced the featured speaker—Professor William C. Craig, head of the Department of Speech at the College of Wooster. Widely known in literary and theological fields, Professor Craig entertained the audience with his highly humorous account of "The Anatomy of a Pun."

Congratulations and good wishes from all in the 11th District were tangibly expressed to Dr. and Mrs. Meredith in the presentation of a pair of silver candelabra.

Northwest Ohio Heart, Cancer, Stroke Group Organized

Dr. Edward L. Burns, director of the Toledo Hospital Research Institute, was elected chairman of the Northwest Ohio Regional Medical Program at a meeting of representatives from 20 counties at Bowling Green State University campus in June.

Other officers are Dr. Brian Bradford, Toledo, vice-chairman; Dr. William Collins, Lima, recording secretary; Sister Mary Verona, Toledo, corresponding secretary; and Frank Kinn, Fostoria, fiscal officer.

The group is in process of preparing an application to the National Institutes of Health for a planning grant under Public Law 88-239, or the Heart, Cancer, and Stroke Amendments of 1965.

The American Tobacco Company recently was cleared by a Federal Court jury in Hartford, Conn., of liability in the death of a cancer victim. According to the company's news release, the legal case was the 50th suit concluded against members of the tobacco industry based on the smoking and health controversy. It further states that in none of the cases has a defendant company been found liable.

Teenage Athletics ...

Fourth Postgraduate Institute for Physicians Scheduled In Columbus, for August 16-17, Under Joint Sponsorship

THE Fourth Postgraduate Institute for Physicians on Medical Aspects of Teenage Athletics will be held at the Fort Hayes Hotel in Columbus on Wednesday and Thursday, August 16-17, 1967. This program is jointly sponsored by the Ohio State Medical Association, the Ohio High School Athletic Association, and the Ohio State University College of Medicine.

This program designed expressly for physicians, is planned to provide the team physician with current concepts involved in the prevention and care of athletic injuries.

Previous Institutes conducted in 1960, 1962, and 1964 were extremely popular. Many physicians wanting to attend one of these past meetings could not because of limited enrollments. This year there will be facilities for only 125 registrants. If you plan to attend you should send your application in early.

Application should be made on the accompanying coupon and directed to the Ohio State Medical Association, not later than August 14. Registration fee of \$25.00 includes costs of two luncheons and a social hour.

Registration opens at 9:00 A.M. on Wednesday, August 16, on the second floor of the Fort Hayes Hotel, 30 W. Spring St., Columbus.

A block of sleeping rooms has been set aside for participants of this Institute. Room reservations should be made directly with the hotel.

Program events will be in the Fort Hayes Hotel, except for Thursday afternoon. The program is as follows:

Wednesday Morning—August 16

Registration opens 9:00 A.M.

Presiding—Paul E. Landis, Commissioner, Ohio High School Athletic Association.

Safeguarding Athletes in Ohio High Schools—

Harold A. Meyer, Asst. Commissioner, OHSAA.

Proceedings of the Medical Aspects of Sports Committee: American Medical Association—

Thomas E. Shaffer, M. D., Columbus.

The Physician-Coach Relationship—

Robert E. Reiheld, M.D., Team Physician, Orville.
William Shunkweiler, Coach, Warren High School

"The Pinched Nerve"

Anatomical Considerations—

Jack N. Meagher, M. D., Columbus.

Management—

Richard Patton, M. D., Columbus.

Prevention—

Ernest R. Biggs, Head Trainer, OSU.

Noon Luncheon

(Continued on next page)

REGISTRATION: Postgraduate Institute on Medical Aspects of Teenage Athletics

NAMEM.D.

ADDRESS

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APPLICATIONS MUST BE RECEIVED
BY AUGUST 14

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17 S. High St., Columbus, Ohio 43215

Fee Enclosed
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2 Luncheons and the
Reception at
Ohio Stater Inn
EXTRA
Reception tickets \$3.00
Total Enclosed

(Teenage Athletics Institute—Continued)

Wednesday Afternoon—August 16

Presiding—Sol Maggied, M.D., West Jefferson.

Booth Seminars—

Group 1—Contact Lenses—

R. H. Magnuson, M. D., Columbus, and
Joseph Bitonte, B. E. E., Columbus.

Group 2—Prevention of Heat Illness—

Robert J. Murphy, M. D., Columbus.

Group 3—Traumatic Abdominal Injuries—

Luther M. Keith, M. D., Columbus.

Group 4—Technique of Injection—

Judson D. Wilson, M. D., Columbus.

Group 5—Dental Protection—

William D. Heintz, D.D.S., Columbus.

Ideal Equipment for a High School Training Room—

Ernest R. Biggs

Symposium on the Knee—

Anatomy of Interest; Dangers of Intra-articular Injection

Richard M. Ward, M. D., Columbus.

Common Football Knee Injuries; Indication for Surgery

Mel L. Olix, M. D., Columbus.

Evening Social Hour

Thursday Morning—August 17

Presiding—Walter A. Hoyt, Jr., M.D., Akron.

The Athlete with an Orthopedic Handicap—

Walter A. Hoyt, Jr., M.D.

America's Fastest Growing High School Sport—Wrestling

Rules on Weight Classes—Ohio and Nationwide—

College and High School—

Casey Frederick, OSU Wrestling Coach.

Medical Viewpoint on Weight Loss—

George Owen, M. D.

Adolescence and Wrestling—

Thomas E. Shaffer, M. D.

Quackery in Rx of Athletic Injuries—

Kenneth S. Clarke, Ph.D., American Medical Association.

Treatment Nuggets in Management of Athletic Injuries—

John R. Jones, M.D., Toledo.

Marvin R. McClellan, M.D., Cincinnati.

Sanford Press, M.D., Steubenville.

Noon Luncheon

Thursday Afternoon—August 17

St. John Arena—OSU Campus

Presiding—Robert J. Murphy, M.D.

Latest Techniques in a Physical Training Program—

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Mr. Swengros.

"FOOTBALL 1967"—

W. W. Hayes

Head Football Coach

Ohio State University

Adjournment at 4:00 P.M.

**Internal Medicine Group Sponsors
Cleveland Area Panel Series
On Socio-Economic Topics**

A series of panel discussions designed to aid physicians who have completed, or nearly completed, their training, will be presented by the Cleveland Society of Internal Medicine as part of The Candidate Program sponsored by the Ohio Society of Internal Medicine. The purpose of the panels will be to prepare the physician for practice by indoctrination into the socio-economics of medicine.

There will be four sessions with the following subject matter to be discussed by experts selected for their knowledgeability:

1. The Physical Aspects of Starting a Practice (September 6); choice of type of practice—academic, research, industrial, or private—group or solo; location of office; affiliations with hospitals.

2. The Financial Aspects of the Practice of Medicine (November 8); how to set fees; how to accomplish adequate collections; the keeping of financial records; proper billing procedures.

3. Insurance Problems (January 3); how to handle patient insurance as well as individual liability; health and accident, life, and other forms of insurance.

4. Office Records and Legal Problems (March 6); what constitutes an adequate record of the patient; how to minimize possible legal problems.

The programs will be held at the Academy of Medicine of Cleveland, 10525 Carnegie Avenue, Cleveland, on the dates indicated. A program listing the participating speakers will be published prior to each session. All physicians interested in attending are invited to communicate with Edward Hahn, M.D., Westgate Medical Arts Center, Fairview Park, Ohio 44126.

Dr. James M. Smith, Hamilton, was cited with a distinguished service award by his Alma Mater, the University of Chicago, at the 27th annual awards assembly held recently on the Chicago campus.

Ad Astra

Melville Darwin Ailes, M.D., Sidney; University of Cincinnati College of Medicine, 1912; aged 84; died June 2; former member of the Ohio State Medical Association. Dr. Ailes retired as Akron health commissioner in 1954 after 27 years in that post. He moved to Sidney the following year. Dr. Ailes held degrees both in medicine and law. He was a veteran of World War I and held memberships in several Masonic bodies. Surviving are two sons and a daughter.

Jack Maurice Appel, M.D., Cleveland; Ohio State University College of Medicine, 1927; aged 76; died June 24; member of the Ohio State Medical Association, the American College of Chest Physicians, and the American Thoracic Society. A practitioner of long standing in Cleveland, Dr. Appel's private practice was in the field of chest diseases. He was also associated with a number of hospitals and clinics in the treatment of tuberculosis. He was president of the Circle Workshop, served as president of the Cleveland Chest Society, and was active in the Temple and its men's club. Among survivors are his widow, a daughter, his mother, four brothers, and two sisters.

Harry R. Barr, M.D., Cleveland; New York Medical College, 1936; aged 55; died June 10; member of the Ohio State Medical Association, and the American Medical Association. Dr. Barr was a native of Cleveland where his father, the late Dr. Harry R. Barr, Sr., also practiced. The younger Dr. Barr specialized in proctology, and retired in 1963 because of ill health. He was a veteran of World War II, having served in the Navy Medical Corps. Surviving are his widow and a sister.

Henry Tracy Clark, Cincinnati; Eclectic Medical College, Cincinnati, 1923; aged 69; died February 8. Dr. Clark was a practitioner of many years standing in Cincinnati.

Charles William Consolo, M.D., Tiffin; St. Louis University School of Medicine, 1938; aged 56; died June 21; member of the Ohio State Medical Association and the American Medical Association. Dr. Consolo began his practice in Tiffin in 1939 and returned there after service in the Medical Corps during World War II. His practice was general, with some heart specialty work. Among affiliations he was a member of the American Legion, the Elks Lodge, Chamber of Commerce, the Catholic Church,

and the Knights of Columbus. Survivors include his widow, three sons, and a brother.

Isaac Wilson Curtis, M.D., New Concord; Ohio State University College of Medicine, 1931; aged 69; died May 26; member of the Ohio State Medical Association and the American Medical Association. A practitioner in the New Concord area for some 35 years, Dr. Curtis was active in numerous community affairs. He was a past president of the Muskingum County Medical Society, a former member of the county board of health, member of the local board of trade, member of the Methodist Church, several Masonic bodies, the Odd Fellows Lodge and the Lions Club. Among survivors are his widow, four sons, a brother, and a sister.

Harold Francis Downing, M.D., Lebanon; University of Cincinnati College of Medicine, 1921; aged 69; died March 27; member of the Ohio State Medical Association, the American Medical Association, and the American Academy of Pediatrics; diplomate of the American Board of Pediatrics. A practitioner of long standing in Cincinnati, Dr. Downing specialized in the field of pediatrics and was on the faculty of the University of Cincinnati College of Medicine.

Ferdinand F. Fledderjohann, M.D., New Bremen; Jefferson Medical College of Philadelphia, 1903; aged 90; died June 15; member of the Ohio State Medical Association and the American Medical Association. A native of Auglaize County, Dr. Fledderjohann served most of his years of practice there; his practice in New Bremen extending from 1918 to 1962. Among affiliations, he was a member of the United Church of Christ. A son survives.

Frank Raymond Ford, M.D., Gallipolis; Vanderbilt University School of Medicine, 1922; aged 70; died March 9; former member of the Ohio State Medical Association. Dr. Ford moved to Gallipolis in the mid 1950's, and was associated with the Gallipolis State Institute.

William L. Gilmore, M.D., East Liverpool; Creighton University School of Medicine, 1940; aged 52; died June 14; member of the Ohio State Medical Association and the American Medical Association; Fellow of the International College of Surgeons and of the American College of Surgeons. A native of East Liverpool, Dr. Gilmore's practice there

began in 1947. In addition to his surgical practice, he was associated with the East Liverpool Extended Care Center. He was a veteran of World War II, and among affiliations was a member of the Presbyterian Church. Survivors include his widow, Dr. Edith S. Gilmore, a son, a daughter, and a sister.

Emmett Lorenzo Hooper, M.D., Dayton; Ohio State University College of Medicine, 1912; aged 77; died March 13; former member of the Ohio State Medical Association, member of the American Psychiatric Association; diplomate of the American Board of Psychiatry and Neurology. A veteran of World War I, Dr. Hooper served with the Veterans Administration and was formerly superintendent of the Dayton State Hospital.

McKinley London, M.D., Cleveland; Cornell University Medical College, 1926; aged 65; died June 21; former member of the Ohio State Medical Association, and the American Academy of Allergy; Fellow of the American College of Surgeons; diplomate of the American Board of Internal Medicine. Dr. London's practice in Cleveland extended from 1930 to 1955, when he retired for health reasons. During World War II he served with the Navy Medical Corps.

Alice Franklin Lyle, M.D., Cincinnati; University of Cincinnati College of Medicine, 1920; aged 73; died March 12; former member of the Ohio State Medical Association.

Maurice R. McGarvey, M.D., Toledo; University of Toronto Faculty of Medicine, 1924; aged 68; died June 6; member of the Ohio State Medical Association and the American Medical Association. A veteran of World War II, Dr. McGarvey moved to Toledo in the late 1940's. His specialty was internal medicine.

Edward Chase Morey, M.D., Franklin; Eclectic Medical College, Cincinnati, 1922; aged 87; died June 10; former member of the Ohio State Medical Association. Dr. Morey practiced in Franklin from

1922 to 1942, when he moved to Grand Rapids, Mich. He returned to the Warren County community in 1962. Affiliations included memberships in several Masonic bodies. Among survivors are his widow and three sons.

Francis R. C. Patterson, M.D., Lorain; University of Toronto Faculty of Medicine, 1922; aged 72; died June 25; member of the Ohio State Medical Association, the American Medical Association, and the American Academy of General Practice. Dr. Patterson's practice in Lorain extended over some 38 years, and included an early association with the U.S. Steel Corporation there. He is survived by his widow and a son, Dr. James B. Patterson, with whom he was associated in practice.

George B. Roth, M.D., Mt. Eaton; University of Michigan Medical School, 1909; aged 88; died May 23; former member of the Ohio State Medical Association. A native of Mt. Eaton, Dr. Roth returned there following his retirement. For many years he was in Washington, D. C., where he was associated with the George Washington University Department of Pharmacology and wrote extensively on subjects related to pharmacology and medicine. His widow and a daughter survive.

John V. Wilber, M.D., Novelty, Geauga County; Western Reserve University School of Medicine, 1950; aged 49, died June 11; recent member of the Ohio State Medical Association and the American Medical Association; member of the American Academy of Pediatrics; diplomate of the American Board of Pediatrics. Since March of 1966 Dr. Wilber had been physician for the Cleveland Area Lamp Division of the General Electric Company. From 1953 to 1966 he specialized in pediatrics with a group practice in Warren. He was associated with numerous professional and health organizations, and with school athletic groups; was a member of the Christian Church and the Masonic Lodge. Surviving are his widow, four sons, two daughters, his parents, a sister, and a brother.

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TOLEDO: Suite 212, 4334 W. Central Ave., (419) 531-4981, R. E. Stallter

OHIO SPECIALTY ORGANIZATIONS PRESIDENTS AND SECRETARIES

Ohio Specialty Societies in many instances cooperated in sponsoring programs in connection with the Ohio State Medical Association Annual Meeting, many of them combining their programs with those of the OSMA Specialty Sections. Some organizations hold meetings at other times of the year. Following are names and addresses of officers of Specialty Societies announced to *The Journal* before this issue went to press.

Ohio Chapter, American College of Chest Physicians — President, John L. Friedman, M.D., 2010 William H. Taft Road, Cincinnati, Ohio 45219; Secretary-Treasurer, Constantine Vishnevsky, M.D., Molly Stark Hospital, P. O. Box 367, Canton, Ohio 44701.

Ohio Ear, Nose, and Throat Society — President, Richard L. Ruggles, M.D., 10515 Carnegie Avenue, Cleveland, Ohio 44106, (also Chairman of Section on Ear, Nose, and Throat); Secretary, L. Reed Cranmer, M.D., 3939 Monroe Street, Toledo, Ohio 43606, (also Secretary of Section on Ear, Nose, and Throat).

Ohio Society of Internal Medicine — President, Leonard P. Caccamo, M.D., 2111 Belmont Avenue, Youngstown, Ohio 44505; Secretary-Treasurer, Edward O. Hahn, M.D., Westgate Medical Arts Center, Fairview Park, Cleveland, Ohio 44126.

Ohio Neurosurgical Society — President, Curwood R. Hunter, M.D., 506 Oak Street, Cincinnati, Ohio 45219, (also Chairman of Section on Neurological Surgery); Secretary, Donald F. Dohn, M.D., 2020 East 93rd Street, Cleveland, Ohio 44106, (also Secretary of Section on Neurological Surgery).

Ohio Ophthalmological Society — President, James E. Bennett, M.D., 5500 Ridge Road, Cleveland, Ohio 44129; Secretary-Treasurer, Robert H. Magnuson, M.D., 150 East Broad Street, Columbus, Ohio 43215.

Ohio Orthopaedic Society — President, John Q. Brown, M.D., 1275 Olentangy River Road, Columbus, Ohio 43212, (also Chairman of Section on Orthopaedic Surgery); Secretary-Treasurer, Paul R. Miller, M.D., 340 East State Street, Columbus, Ohio 43215, (also Secretary of Section on Orthopaedic Surgery).

Ohio Society of Pathologists — President, Paul N. Jolly, M.D., Christ Hospital, 2130 Auburn Avenue, Cincinnati, Ohio 45219, (also Chairman of Section on Pathology); Secretary, Robert G. Thomas,

M.D., Elyria Memorial Hospital, Elyria, Ohio 44035, (also Secretary of Section on Pathology).

Ohio Chapter, American Academy of Pediatrics — President, Homer A. Anderson, M.D. 196 East State Street, Columbus, Ohio 43215; Secretary-Treasurer, George A. Smith, M.D., 908 North Fountain Street, Springfield, Ohio 45504.

Ohio Society of Physical Medicine and Rehabilitation — President, Roy Starkey, M.D., 3956 Central College Road, Westerville, Ohio 43081; Secretary, John L. Melvin, M.D., 410 West 10th Avenue, Columbus, Ohio 43210, (also Chairman of Section on Physical Medicine and Rehabilitation).

Ohio Psychiatric Association — President, Victor Victoroff, M.D., 2231 Taylor Road, Cleveland, Ohio 44112; Secretary, William Holloway, M.D., 261 West Cedar Street, Akron, Ohio 44307; Program Chairman, Charles A. DeLeon, M.D., 2040 Abington Road, Cleveland, Ohio 44106, (also Chairman of Section on Psychiatry and Neurology); Executive Secretary, Mr. Gene P. King, 88 East Broad Street, Columbus, Ohio 43215.

Ohio State Radiological Society — President, George Nicoll, M.D., Miami Valley Hospital, Dayton, Ohio 45420; Secretary, Robert Berkebile, M.D., 33 Lakeview Drive, Grafton, Ohio 44044.

Ohio Committee on Trauma, American College of Surgeons — Chairman, Wesley Furste, M.D., 3545 Olentangy River Road, Columbus, Ohio 43214; Secretary-Treasurer, Ray Ebert, M.D., 327 East State Street, Columbus, Ohio 43215; Program Chairman, Joseph Strong, M.D., 409 East Avenue, Elyria, Ohio 44035.

ROSTER OF SPECIALTY SECTIONS CHAIRMEN AND SECRETARIES

Following are names and addresses of chairmen and secretaries of the Ohio State Medical Association Specialty Sections, with some program chairmen. Most of these sections met during the OSMA Annual Meeting in Columbus and elected or re-elected officers. Specialty Sections aid the Committee on Scientific Work to plan programs for the Annual Meeting. These names and addresses are given for the benefit of persons who may wish to correspond with Section officers in regard to program matters.

Section on Anesthesiology — Chairman, David M. Katchka, M.D., 3939 Monroe Street, Toledo, Ohio 43606; Secretary, Paul G. Cressman, Jr., M.D., 599 Hampshire Road, Akron, Ohio 44313.

Section on Ear, Nose, and Throat — Chairman, Richard L. Ruggles, M.D., 10515 Carnegie Avenue, Cleveland, Ohio 44106, (also President, Ohio ENT Society); Secretary, L. Reed Cranmer, M.D., 3939

Monroe Street, Toledo, Ohio 43606, (also Secretary, Ohio ENT Society); Program Chairman, Stephen P. Hogg, M.D., 250 Wm. H. Taft Road, Cincinnati, Ohio 45219.

Section on General Practice of Medicine — Chairman, Glenn W. Pfister, Jr., M.D., 8040 Reading Road, Cincinnati, Ohio 45237; Secretary, Richard C. Brandes, M.D., 2094 Tremont Center, Columbus, Ohio 43221.

Section on Hospital Directors of Medical Education — Chairman, Warren G. Harding, 2nd, M.D., Grant Hospital, 309 East State Street, Columbus, Ohio 43215; Secretary, Lee R. Sataline, M.D., Toledo Hospital, 2142 North Cove Boulevard, Toledo, Ohio 43606; Program Chairman, Robert V. Bachman, M.D., 14600 Detroit Road, Cleveland, Ohio 44107.

Section on Internal Medicine — Chairman, William A. Millhon, M.D., 3600 Olentangy River Road, Bldg. A, Columbus, Ohio 43214; Secretary, Carl G. Thompson, M.D., 938 Hempstead Drive, Cincinnati, Ohio 45231.

Section on Neurological Surgery — Chairman, Curwood R. Hunter, M.D., 506 Oak Street, Cincinnati, Ohio 45219, (also President of Ohio Neurosurgical Society); Secretary, Donald F. Dohn, M.D., 2020 East 93rd Street, Cleveland, Ohio 44106, (also Secretary of the Ohio Neurosurgical Society).

Section on Obstetrics and Gynecology — Chairman, Keith DeVoe, Jr., M.D., 3545 Olentangy River Road, Columbus, Ohio 43214; Secretary, Michael Howett, M.D., Dept. OB and Gyn, University Medical Center, Cincinnati, Ohio 45229.

Section on Occupational Medicine — Chairman, E. R. Plunkett, M.D., 256 Norton Avenue, Barberton, Ohio 44203; Secretary, Lloyd B. Tepper, M.D., Kettering Laboratory, Eden & Bethesda, Cincinnati, Ohio 45219.

Section on Ophthalmology — Chairman, William E. Sovik, M.D., 207-10 Mahoning Bank Bldg., Youngstown, Ohio 44503; Secretary, Clarence L. Hans, Jr., M.D., 807 Provident Bank Bldg., 7th and Vine Streets, Cincinnati, Ohio 45202.

Section on Orthopaedic Surgery — Chairman, John Q. Brown, M.D., 1275 Olentangy River Road, Columbus, Ohio 43212, (also President of Ohio Orthopaedic Society); Secretary, Paul R. Miller, M.D., 340 East State Street, Columbus, Ohio 43215, (also Secretary of Ohio Orthopaedic Society).

Section on Pathology — Chairman, Paul N. Jolly, M.D., Christ Hospital, 2130 Auburn Ave., Cincinnati, Ohio 45219, (also President of Ohio Society of Pathologists); Secretary, Robert G. Thomas, M.D., Elyria Memorial Hospital, Elyria, Ohio 44035, (also Secretary of Ohio Society of Pathologists).

Section on Pediatrics — Chairman, Malcolm L. Robbins, M.D., 4373 East Livingston Avenue, Columbus, Ohio 43227; Secretary, Lester W. Sanders, Jr., 7777 Montgomery Road, Cincinnati, Ohio 45236.

Section on Physical Medicine and Rehabilitation — Chairman, John L. Melvin, M.D., University Hospital, Dept. of Physical Medicine, 410 West 10th Avenue, Columbus, Ohio 43210, (also Secretary of Ohio Society of Physical Medicine and Rehabilitation); Secretary, Emily R. Hess, M.D. Good Samaritan Hospital, Cincinnati, Ohio 45220.

Section on Plastic Surgery — Chairman, Clifford L. Kiehn, M.D., 10605 Chester Avenue, Cleveland, Ohio 44106; Secretary, H. William Porterfield, M.D., 1100 Morse Road, Columbus, Ohio 43224; Program Chairman, Robin Anderson, M.D., 2020 East 93rd Street, Cleveland, Ohio 44106.

Section on Psychiatry and Neurology — Chairman, Charles A. DeLeon, M.D., 2040 Abington Road, Cleveland, Ohio 44106, (also program chairman for section and society); Secretary, Philip C. Rond, Jr., M.D., 130 South Davis Avenue, Columbus, Ohio 43222.

Section on Radiology — Chairman, Lee S. Rosenberg, M.D., Jewish Hospital, Cincinnati, Ohio 45229; Secretary, (to be announced).

Columbus Physician Is Honored for 34 Years of Military Service

Dr. Anthony Ruppertsberg, Jr., Columbus, Army Medical Corps Colonel and chief surgeon of the Ohio National Guard, was honored with a troop review at the Camp Perry summer encampment recently. The occasion was the announcement of his retirement from National Guard activities after 34 years of service in that unit.

He is a veteran of some three decades of summer encampments with the Guard as well as other activities in Guard service. During World War II he was commander of a station hospital in the Pacific Theater of Operations.

Another honor was a citation by the Commanding General of the First United States Army, awarding Colonel Ruppertsberg the Army Commendation Medal for "rendering exceptionally meritorious service" as chief of staff of the Ohio Army National Guard from February 1962 to June 1967, in addition to his duties as State Surgeon General.

Dr. Ruppertsberg is a practitioner in the field of obstetrics and gynecology and is associate clinical professor of obstetrics and gynecology at Ohio State University College of Medicine. For many years he has been chairman of the Ohio State Medical Association Committee on Maternal Health, a group which has distinguished itself by pointing the way to better obstetrical practices through studies of causes of maternal mortality in Ohio.

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BUTLER—Brady Randolph, President, 128 North Front Street, Hamilton 45011; Mr. Charles G. Greig, Executive Secretary, 110 North Third Street, Hamilton 45011. 3rd Wednesday monthly.

CLERMONT—Noco Capurro, President, 481 Craig Road, Cincinnati 45244; Albert W. Van Sickle, Secretary, Box 365, Batavia 45103. 3rd Wednesday monthly except July, August and December.

CLINTON—H. Richard Bath, President, 290 West Main Street, Wilmington 45177; Mary R. Boyd, Secretary, Box 629, Wilmington 45177. 4th Tuesday monthly.

HAMILTON—Elmer R. Maurer, President, 3942 Northcliff Lane, Cincinnati 45220; Mr. Edward F. Willenborg, Executive Secretary, 320 Broadway, Cincinnati 45202. 3rd Tuesday monthly.

HIGHLAND—Thomas L. Jones, President, 528 South Street, Greenfield 45123; Glenn B. Doan, Secretary, 614 Jefferson Street, Greenfield 45123.

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Second District

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322 Second Ave.

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CLARK—H. B. Elliott, President, 25 West Harding Road, Springfield 45504; Mrs. Marion L. Wilcoxson, Executive Secretary, 616 Building, Room 131, 616 North Limestone Street, Springfield 45503. 3rd Tuesday monthly.

DARKE—E. Westbrook Browne, President, 330 West 4th Street, Greenville 45331; Giles Wolverton, Secretary, Darke County Department of Public Health, Court House, Greenville 45331. 3rd Tuesday monthly.

GREENE—Richard A. Falls, President, 1148 North Monroe Drive, Xenia 45385; Mrs. C. K. Elliott, Executive Secretary, 225 Pleasant Street, Xenia 45385. 2nd Thursday monthly, except July and August.

MIAMI—Robert L. Sutton, President, 423 West Main Street, Tipp City 45371; Robert J. Price, Secretary, 760 North West-edge Drive, Tipp City 45371. 1st Tuesday monthly.

MONTGOMERY—W. J. Lewis, President, 2567 Far Hills Avenue, Dayton 45419; Mr. Robert F. Freeman, Executive Secretary, 280 Fidelity Medical Building, Dayton 45402. 1st Friday monthly.

PREBLE—John D. Darrow, President, 228 North Barron Street, Eaton 45320; J. R. Williams, Secretary, 228 North Barron Street, Eaton 45320. December yearly.

SHELBY—George J. Schroer, President, 322 Second Avenue, Sidney 45365; Alfonsas Kisielius, Secretary, Ohio Building, Sidney 45365.

Third District

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1051 Harding Memorial Pky.

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AUGLAIZE—R. S. Sobocinski, President, 7 South Blackhoof Street, Wapakoneta 45895; J. F. Bowling, Secretary, 319 West Spring, St. Marys 45885. 1st Thursday odd months, with exception of July.

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VAN WERT—Wilmer L. Iler, President, Medical Arts Building, Fox Road, Van Wert 45891; Fred E. Culler, Secretary, 938 South Washington Street, Van Wert 45891. 4th Friday monthly.

WYANDOT—Joseph J. Browne, Acting President and Secretary, 777 North Sandusky Street, Upper Sandusky 43351. 2nd Tuesday monthly.

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3939 Monroe St.

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WILLIAMS—Robert Bemis, President, 210 Morris Drive, Montpelier 43543; Victor Boerger, Secretary, Edgerton 43517. 3rd Tuesday monthly.

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GEAUGA—C. K. Adrian, President, Medical Arts Building, 13221 Ravenna Road, Chardon 44024; Mrs. Martha Withrow, Executive Secretary, P. O. Box 249, Chardon 44024. 2nd Friday monthly.

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MORROW—Lowell Murphy, President, 209 South Marion Street, Cardington 43315; David James Hickson, Secretary, 712 Baker Street, Mt. Gilead 43338. 1st Tuesday monthly, 6:30 P. M. dinner.

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1749 Cleveland Road

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HURON—Richard L. Jackson, President, 388 E. Howard Street, Willard 44890; John Rosso, Secretary, 218 Myrtle Avenue, Willard 44890. 2nd Wednesday of February, April, June, August, and December.

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WAYNE—Lyle Moyer, President, Dalton 44618; R. J. Watkins, Secretary, 1736 Beall Avenue, Wooster 44691. 2nd Wednesday, alternate months.

Toll in Bicycle, Motorcycle Rider Deaths Still Rising in Ohio

In the last six years 247 bicyclists have been killed in Ohio. The toll is rising steadily, jumping from 23 bicyclists in 1961 to 52 last year, The Ohio Department of Highway Safety reported. In 1966, after only 12 bicycle deaths in the first six months, 21 were killed in July.

Six have died in the first four months this year. But last year the total for the first four months was only five, and the total then soared to 52.

The motorcyclists, too, pose a problem according to safety officials. The five-month death toll this year was 38 motorcyclists, with 14 killed in May alone. The motorcycle toll is climbing steadily, from 32 in 1961 to 78 in 1965, and more than 100 last year.

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Toledo thus smashed previous marks set in Detroit, Flint, the State of Rhode Island and other areas, the sponsors said.

Dr. John R. Jones, Academy president and chairman of the drive, credited the success to a major public information program in which nearly 25 newspapers, radio, and television outlets participated, along with extensive assistance by volunteers.

Largest contributor of funds was the Toledo Area Community Chest which donated \$4,000 toward cost of the vaccine.

The Toledo campaign, one of many conducted throughout the country, vaccinated youngsters be-

tween 1 and 12 against rubeola. The shots were given with jet-injectors at 17 Toledo area schools.

The campaign was a joint effort of doctors, medical auxiliaries, pharmacists, nurses, schools, amateur radio operators, newspapers, television, and radio stations, banks, civic organizations, transit companies, hospitals, health departments, and the City of Toledo.

Community Pediatric Program Set Up in Cincinnati

The University of Cincinnati College of Medicine has announced the establishment of a Community Pediatric Program under the directorship of Edward L. Pratt, M. D., professor and chairman of the Department of Pediatrics of the University of Cincinnati.

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CHANGING CONCEPTS IN PSYCHIATRY IN OHIO

By WENDELL A. BUTCHER, M.D., Columbus

WHAT will the medical historian, looking back at the 20th century, consider to be the most important advance over the past hundred years? Right now, some two-thirds along the way, it seems possible that the discovery of the antibiotics and the conquest of the infectious diseases may lead the list. However, powerful contenders still have time to forge into the lead. Perhaps the discovery of the secret of cancer, the control of heart disease, or the perfection of the technique supplying artificial or transplanted organs may head the list. I would like to suggest that a dark horse may prevail before the year 2000; that is, widespread alleviation of mental and emotional illness.

The American public is becoming rapidly and increasingly aware of the fact that a large sector of its misery and suffering is not an inevitable and unavoidable consequence of living. Mental anguish, depression, anxiety, guilt, fear, and remorse may be preventable and curable.

Beginning in the General Hospital

The care of the mentally ill in this country began in the general hospital about 150 years ago. The number of mentally disturbed patients then quickly overran the wards assigned to them and it was not long before they were removed to separate hospitals of their own. The movement was toward placing patients in quiet, rural hospitals, remote from the crowded urban centers, and in most cases, away from medical centers.

Thus psychiatry began its isolation from medicine, an isolation necessary, not because the people demanded it, but because it represented too great a demand on the available facilities. Because of this physical-isolation, a kind of emotional isolation concerning the mentally disturbed developed both within the profession of medicine and within the ranks of the general public—a kind of out-of-sight, out-of-mind philosophy. By the beginning of the 20th century, all but a very few physicians were willing to allow the medical problem of mental disturbance be in the hands of the government. Here it remained, and as one of our leading politicians is said to have stated a few years ago, "There isn't a

single vote in a state hospital." It remained there until World War II brought it back to the consciousness of the individual.

I am impressed by a statement made by Richard C. Cornuelle recently in discussing "The Renaissance of America's Third Force":

"We are moving into the last third of the 20th century. In the year 2000, when we look back at this century, I think we are going to find that the first third was a period in which we began to sense the great strength and productive capacity of the commercial sector of our society and at the same time began to realize that commercial activity alone could not accomplish all of America's ideals.

"I think that we are going to look back on the second third of the century as a period in which we experimented freely and extravagantly with government action on social problems—but developed a growing realization of the sharp limits to the effectiveness of government action.

"I think we are going to look back on the last third of the century as a time when we rediscovered the astounding vitality and problem solving capacity of the independent sector and put it to work in America."

Returning to the 'Independent Sector'

If we can think of the individual community as being the independent sector that Mr. Cornuelle speaks of, we, I believe, are in the process of returning the problems of the mentally disturbed to the independent sector.

In 1965, among some 9000 general hospitals in the United States, about 1400 report that they care for the mentally disturbed. In fact, there are really probably only five to six hundred which actually have effective services for the mentally ill. Nonetheless, more patients are now first admitted to general hospitals than to mental hospitals, either privately or governmentally operated. Going along with this trend, there are now 35 general hospitals in Ohio which provide partial services. I would make this prediction—that within the next ten years practically all general hospitals will provide services for the mentally ill. These services will probably

Presented before the Section on Psychiatry and Neurology at the OSMA Annual Meeting in Columbus, May 18, 1967.

be established with a state agency providing approval based on minimum standards delineating type, extent, and kind of services to be offered. I personally hope, however, that the Joint Commission on Accreditation of Hospitals will become the *de facto* body in establishing these standards.

The prediction that virtually all general hospitals in the future will include facilities for the mentally disturbed, is an outgrowth of the American peoples' acceptance of this medical problem. They are accustomed to receiving medical care in a general hospital. If we are really to accept that which the people of Ohio have shown that they believe, that is, that mental disturbance is a medical problem, then we must provide for its treatment and care with the other medical problems facing us. There is no logical reason to assume that mental illness is not a medical problem, and therefore it should be treated as such and treated where the patient desires to go.

It has long been my feeling that we in medicine have and do tend to plan and think in terms of what has happened in the past. I think we must recognize that although the past undoubtedly does provide guidelines, creative thinking, that is, a stronger attempt to peer into the future, which has become the hallmark of successful business, is indicated. A friend of mine in the field of economic predictions has indicated to me that his group feels that the field of drug research will in the next ten years be in the top ten categories in the rate of increase of all types of business. I am sure many of these new drugs to be developed will be for use in the psychiatric field. Among these, I expect to find some that are of much greater value in the control of such illnesses as schizophrenia and the depressions than those we are now using. I would expect that in these particular types of illness, cures per se, rather than control, will be accomplished.

Role of Non-Psychiatric Physician

If these predictions become a reality, I feel that many general physicians will find in themselves the desire to treat these illnesses. We will see a marked increase in the number of physicians whose primary interest is not necessarily psychiatry but who will be prepared to use these drugs in the general hospital setting. These physicians will be provided from two major sources:

(1) The first source stems from increased attention to psychiatry in our medical schools. For instance, at Ohio State University each senior now spends at least two full months of his senior year in inpatient and outpatient psychiatry, in addition to lecture courses earlier in his student career and combined with experience in psychosomatic medicine in all the clinics.

(2) A determined effort in continuing education in psychiatry for the nonspecialist is being carried

out in the post graduate seminars of our medical schools. Of special interest, moreover, is the recent grant of funds to the Ohio Academy of General Practice by the National Institute of Mental Health for a pilot program for this purpose.

As you may be aware, Ohio is not one of the leading states obtaining federal funds for such a program, which may be a good thing. For the past few years, the American Psychiatric Association and the American Medical Association have joined in sponsoring regional meetings where those physicians desiring experience in this field may exchange ideas. Ohio's grant will probably be spent in two to three geographical areas. Psychiatrists acting in conjunction with a "visiting elder," i.e., a local respected physician, will bring ten to fifteen general practitioners the understanding of psychiatric principles. The general practitioners will in turn apply these principles to their individual practices. In a very few areas in Ohio this has already been attempted without federal funding. The program of continuing education in psychiatry (CEP), whether it be funded from federal or local sources, will continue to grow, I believe. Ohio's people are demanding from their physicians such understanding and service. In fact, it is essentially the nonspecialist who has sought this program.

Increase in Specialists

While it is not expected that long term treatment such as psychotherapy of the psychiatric patient will be in the hands of the nonspecialist, there will be much more consultative help available to him. In 1931 when I entered pre-med, 0.9 per cent of the physician population in the United States held membership in the American Psychiatric Association. In 1962, 5.3 per cent of physicians were members. This rate of growth has been on a continually increasing basis. In 1953, 5 to 7 per cent of the medical students were going into psychiatry, and in 1965 and 1966, approximately 10 per cent were going into this specialty. Incidentally, Harvard Medical School now finds 15 to 18 per cent of its students entering psychiatric training.

That these facilities and trained personnel be available to our citizens, of course depends on the people's ability to finance them. Psychiatric care obviously creates a major financial crisis in any family. Recognizing this, many private insurance companies have added such care to their major medical health plans. In addition, one union, the United Auto Workers, has taken the lead in providing its members and their families with mental illness care as a fringe benefit. This benefit permits private psychiatric care for the working man, both in the office and the general hospital.

I believe most of you feel that the earlier the psychiatric patient receives treatment, the less likely he is to develop a long-term illness. The terms of the auto union's contract encourages early attention to

such illnesses by paying in full the cost of the early visits and scaling down payments as the sickness becomes chronic.

Survey of Needs

In 1963 to 1965, assisted by federal grants, Ohio surveyed its needs in the field of mental illness and mental retardation. This survey, carried out by citizens, led by a physician, and sponsored by the Governor, found that Ohio needed facilities in centers serving both rural and urban population. As a result of this survey, legislation has been passed under the title of the Comprehensive Community Mental Health Act which provides for such centers, financed on a local-state-federal participation basis, both for construction and operation. A county, or group of counties, must form a mental health and retardation board of from nine to fifteen members appointed by the county commissioners. Of these members, two must be physicians who have demonstrated interest in mental illness or mental retardation.

These centers, serving population groups of approximately 250,000 persons each, will coordinate existing services and provide new services so that each community will be provided with diagnostic services, outpatient services, inpatient services, day care, night care, consultive services, educational services and coordinating services. They will be able to charge fees scaled to the treated individual's income for services rendered, but no person will be refused treatment because of his inability to pay for such treatment. It is to be hoped that such centers will be located within an hour's drive of every person in Ohio.

The Role of Rehabilitation

You may have noted that in naming the types of services to be made available through the Mental Health and Retardation Centers, I did not mention rehabilitation. In 1963 and 1965 the Bureau of Vocational Rehabilitation was given the duty of providing rehabilitation for the mentally disturbed. This departure from the Bureau's traditional duty toward rehabilitation of the physically handicapped has only just begun to make itself felt. Task forces are being formed throughout the state to assist in establishing those facilities, finding the manpower, and designing techniques needed in local community centers to provide for adequate rehabilitation. The availability of such services will stimulate a much greater understanding of the need of rehabilitation for the complete treatment of both the mentally ill and mentally retarded. The Comprehensive Mental Health Centers must be closely associated with any rehabilitation centers or efforts which may be developed. It is probable that if any services are already available in a community, these will not be repeated in either type of center, but will be in effect purchased by contract by the local board of the centers.

Many people had been depending upon the Governor's proposal for an Ohio Bond Commission to supply the income to build the centers mentioned above. As you are aware, many more people in Ohio decided that it was not to be. Perhaps these people have decided that they desire their community to function as an independent sector and decide for themselves how, when, and where they will meet their own community needs. I note with deep satisfaction that in the past few years whenever a bond issue has been on the ballot for the purpose of providing facilities for the mentally retarded, it has passed by an overwhelming majority. Perhaps the "independent sector" is involved in solving its problems.

Other legislation which is of prime importance to the mentally ill and retarded in Ohio is presently being considered in our state capital in the form of bills to separate the Department of Mental Hygiene and Correction into two departments and provide the Department of Mental Hygiene with a Board of Mental Hygiene which will have regulatory power similar to the present Board of Health. Both of these bills are either sponsored by, or actively approved by the OSMA in principle and, I feel, strongly deserve your support through your state legislators.

Thus we see that Ohio will have Mental Health and Retardation Centers covering both our rural and urban areas. These will be closely integrated, with the present state hospital and retarded school systems acting as long term inpatient treatment centers when needed. However, with the community-centered general hospital and Comprehensive Community Mental Health Centers providing increased treatment facilities, the role of the state hospital is very likely to change. Recently a colleague made the statement that soon the state hospital would house only the very sick patient. This is probably a true statement for the immediate future. It will obviously require several years before the centers and general hospital wards are established, but given time, I see the state hospital as a treatment facility, becoming as little used as are the tuberculosis hospitals of yesteryear.

Perhaps our state hospitals will become true rehabilitation centers—centers in educational, social, and industrial training for the mentally disturbed who will then be returned to our metropolises. At any rate, the state hospital will become, I believe, the center for a kind of regional leadership in the treatment of the mentally disturbed.

Let us look for a moment at our growing population. Much has been said in the past few years about the needs of geriatric patients. I would submit to you that a much greater need for psychiatric understanding is at the other end of the patient spectrum. It is estimated that by 1975 more than 50 per cent of our population will be under the age of

25. The fields of child, adolescent, and young adult psychiatry must be developed. Here, I feel, psychiatric thinking might do well to abandon its long-standing attitude of being nondirective. The persons here considered are those who have been unable to formulate their own standards and are still trying to answer that most difficult question of *what am I*. Helping them to formulate their answer is basically the responsibility of an adequate home environment. As our society becomes more complex, more interdependent, however, psychiatry must move into this field, perhaps in consultant capacities in our schools, certainly in church-centered activities as have already been developed in all too few of our large urban churches.

In conclusion, then, here are some responses to the question, What are the changing concepts of psychiatry in Ohio?

(1) Psychiatry will become a widely accepted and recognized need both in rural and urban communities.

(2) Psychiatry is truly a part of general medicine, and as such, the general practitioner must assume a more important role on the mental health team, and the psychiatrist must assume his place on the general health team.

(3) The trained psychiatrist must become more and more a consultant rather than the primary source of treatment.

(4) New and much more powerful drugs will become available through research and development for the treatment of the more serious types of mental disturbance.

(5) Now that Heart Disease, Stroke, and Cancer, as well as Highway Safety, have achieved federal status, Mental Illness and Retardation will become more and more a governmental financed responsibility but will be at a local community level.

(6) The acceptance of Mental Illness as a financial responsibility of health insurance plans will become more a reality.

(7) More attention will be paid to the problems of young people.

(8) Preventive psychiatry will become an epidemiological specialty.

So I present to you my dark horse, my Proud Clarion, for the medical derby of the 20th century.

The Sixth National Cancer Conference, sponsored by the American Cancer Society and the National Cancer Institute, will be held at the Denver Hilton Hotel, Denver, Colorado, September 18-20. Details may be obtained by writing Roald N. Grant, M. D., Coordinator, American Cancer Society, 219 East 42nd Street, New York, N. Y. 10017.

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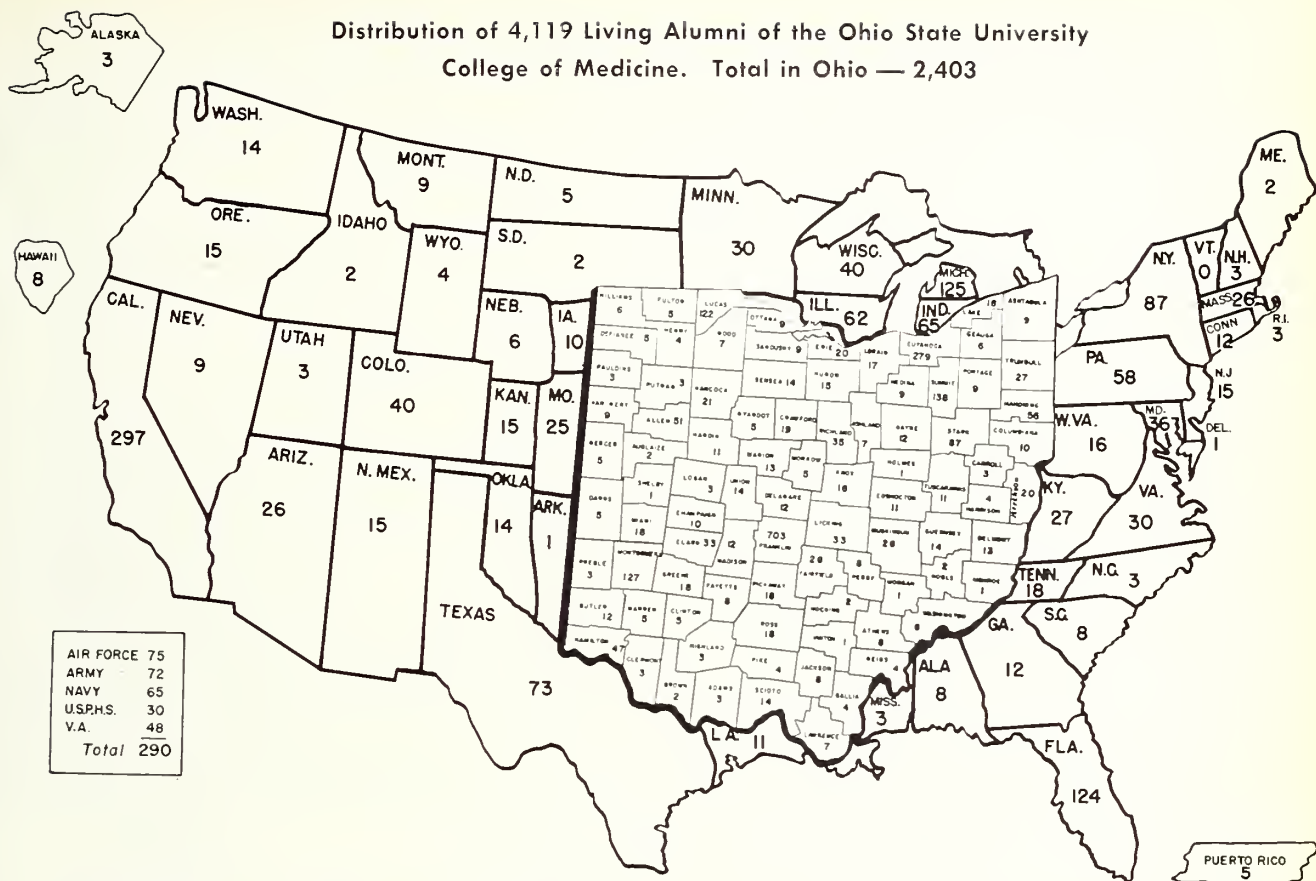
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**Distribution of 4,119 Living Alumni of the Ohio State University
College of Medicine. Total in Ohio — 2,403**



Far-Reaching Influence Shown By Location of Alumni

Where do physicians go after they leave medical school? Numerous research projects have been launched with the intent of answering that question. Perhaps one of the most revealing studies is one, the results of which were reported in a recent brochure published by the Ohio State University College of Medicine in regard to distribution of its alumni.

The above chart shows data from that study. The map is reproduced from the brochure containing "A Six-Year Report of the College of Medicine, Ohio State University, 1961 through 1966." The sketch shows distribution of living alumni of the College of Medicine in 1966.

Of significance is the fact that physician alumni are represented in every county in Ohio. In addition OSU College of Medicine graduates are shown in every state of the Union, with one exception, plus several in Puerto Rico and numerous members in the Armed forces, the Public Health Service, and the Veterans Administration.

An official of the College of Medicine points out that California seems to be a good recruiting area for Ohio physicians because the equivalent of two graduating classes are now residents of that West Coast state. Likewise, the equivalent of two graduat-

ing classes are assigned to the Armed Forces, the U.S. Public Health Service, and the Veterans Administration. Furthermore, enough doctors to make another graduating class have sought the sunny climate of Florida.

In summary, the influence of a medical college such as Ohio State is far-reaching, and extends not only to every area of the state, but to the uttermost parts of the country.

For other phases of the report on progress at Ohio State University College of Medicine, refer to the August issue, beginning on page 1014.

John C. Camp, a senior in the Ohio State University College of Medicine, and his wife, a registered nurse, recently were awarded a fellowship of the Smith Kline & French through the Association of American Medical Colleges, permitting them a 13 weeks tour at medical installations in Kenya.

Dr. Martin D. Keller, head of the Division of Epidemiology and Biometrics at Ohio State University, was principal speaker at luncheon meeting of the Cambridge Rotary Club. His talk centered around the theme, "Can We Control Our Major Killer, Coronary Heart Disease?"



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Socio-Economics of Health Care Program Scheduled in 1968

The American Medical Association has announced scheduling of the Second National Congress on the Socio-Economics of Health Care to be held in the Palmer House, Chicago, March 22 and 23, 1968.

Sponsorship is under the Council on Medical Service and the Division of Socio-Economic Activities of the AMA.

Purpose of the congress is to signify the medical profession's ongoing concern for the effective organization, delivery, and financing of health care services; and, to bring together authorities from medicine, health care administration, social science, education, community planning, and other disciplines to report on new issues and techniques in this area.

The theme is: Meeting the Increased Demand for Health Services.

Under program topics the Second National Congress will:

Evaluate the dimensions of the increasing demand for health services;

Report in depth on specific evolving responses to this demand, including (1) the evolution, organizational patterns, and current status of group practice, (2) changing roles of the medical and allied health professions, and (3) growth in comprehensive community, state, and regional health service planning;

Examine the long-range effects of increasing demand in terms of costs and financing mechanisms, manpower requirements, the role of organized medicine, and legislative developments.

New Members . . .

Following are names of new members of the Ohio State Medical Association certified to the headquarters office during July. List shows name of physician, county, and city in which he is practicing, or in which he is taking postgraduate work.

Athens

Jon P. Tipton, Athens

Clark

William J. Donegan,
Springfield

Cuyahoga

Saroj Aggarwal, Cleveland
John D. DeCosse, Cleveland
Alfredo E. Duarte, Cleveland
Karl W. Hess, Cleveland
Alejandro C. Juguilon,
Cleveland
Muhlis Y. Kaya, Cleveland
Alan J. Sogg, Cleveland
Aaly A. Tambe, Cleveland

Franklin

Sanders M. Farber,
Columbus
Hannelore E. Genaidy,
Columbus

Mohamed E. A. Genaidy,
Columbus

Paul B. Oppenheimer,
Reynoldsburg

Eladio Sotolongo,
Cincinnati

Roberto R. Villalon, Columbus

Hamilton

Michael Howett, Cincinnati

Richard T. Marnell,
Cincinnati

Richard H. O'Dillon,
Cincinnati

Lucas

Edward B. Claxton, Toledo
Ursula L. Ruwe, Toledo

Summit

Richard J. Wherry,
Cuyahoga Falls



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Contains opium ($\frac{1}{4}$ grain) 15 mg. per fluid
ounce.
warning: may be habit forming
Pectin (2½ grains) 162 mg.
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Medical Director

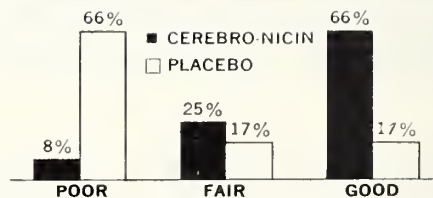
JAMES L. HAGLE, M. B. A.
Administrator

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*A Double-Blind Study of Cerebro-Nicin, Therapy for the Geriatric Patient, R. Goldberg, Jnl. of the Amer. Ger. Soc., June, 1964.

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OSMA Stand Applauded . . .

Ohio's Strong Stand in Regard to Physician Participation In Health Care Planning Is Praised by Out-of-State Doctor

APPLAUSE for the Ohio State Medical Association's firm stand in regard to physician participation in health care planning programs recently was expressed by a doctor from another state.

The OSMA has been waging a constant campaign for a number of years against encroachment of outside forces into the practice of medicine, and, at the same time encouraging physician participation in all planning programs relating to medicine and health. The Association's policy in regard to Government Medical Care Programs was summarized and published in two sections in the May and June issues of *The Journal*.

Following are copies of letters exchanged between Dr. Gordon R. Meyerhoff, of New York City, and Dr. Robert E. Howard, Cincinnati, President of OSMA.

19 Hillside Avenue
Roslyn Heights
New York 11571
June 12, 1967

President
Ohio State Medical Association
Dear Sir:

Please accept my personal applause for your recent stand on areawide health care planning without physician participation. It is a pleasure seeing someone finally recognize that physicians are being excluded from the management of the medical profession.

In this connection, your stand will be idle wind, as much of physicians' blastings are these days, unless it contains teeth. It is imperative that all state associations strongly alert their members to this state of affairs and request them not to sanction any program by participating in it unless the state and local medical societies are called in on the deliberations. None of these plans can work unless physicians participate in the implementation of the plan. The physicians who endorse such plans by implementing them are **displacing themselves** from the management of the medical profession.

As you may know, in some areas some half-baked physician is included on a planning committee to give nominal participation of the medical profession. This is equally unsatisfactory and the requirement should be an official representative of the state or local medical society, whichever is involved in the planning.

And most important thing of all the presence of a physician or even a representative of the state or local medical society must not be taken as an endorsement of any plan, no matter how ideal, if it includes **compulsion** by any party to comply with the plan.

In New York State now, such "planning" is not "planning" but is compulsory regulation: You cannot add one room on to your private hospital without clearance from the State Capitol. In this case, therefore, the mere presence of a physician on such a planning board, even a representative of the State Medical Association, constitutes an endorsement and approval of the compulsory regulation of private medical facilities.

For some unknown reason the physicians of New York State are losing their sense of freedom and don't seem to be able to muster any strength to keep medicine free. The fate of free medicine rests in people like yourself who must take the lead and show that free men must never give up their freedom.

Sincerely yours,
Gordon R. Meyerhoff, M. D.

Ohio State Medical Association
Office of the President
Cincinnati, Ohio
July 1, 1967

Gordon R. Meyerhoff, M. D.
19 Hillside Ave.
Roslyn Heights
New York, N. Y. 11577

Dear Dr. Meyerhoff:

Your letter of June 12th was refreshing and full of views very parallel to ours. I am sure you are speaking from experience when you speak about participation and active representation of state and local medical societies on all planning and service agreements for Health Care.

We believe that Direct Billing and usual, customary, and reasonable fees should be a medical agreement between the patients and doctors not the government. Our recent fight is getting a lot of mileage pro and con and we'll enclose a couple of the clippings. Where did you hear of our action and if you do not have our Medicare Letters or Analysis

of Government Programs please write and we will send them to you, if you promise to help spread our cause.

Thank you for your letter,

Sincerely,
Robert E. Howard, M. D.
President, OSMA.

July 6, 1967

Dear Dr. Howard:

Thank you for your letter of July 1. I greatly appreciate it. Especially to learn of your future plans for free medicine.

Yes, your Executive Secretary sent me your Medicare Letters and the Analysis of Government Programs. And most of the medical news services have been reporting your courageous stand at the forefront of free medicine — Even the AMA which lags far behind your banner of freedom. Those of us throughout the country who are dismayed at the AMA "cooperation" with socialistic forces and who reside in states that are following sheepishly along to the slaughter house see our only salvation in the State of Ohio showing the rest of the physicians in the country how a state medical society can rally the membership to continue to practice free medicine and to demonstrate that it is only physicians

who can institute socialized medicine or continue free medicine: that the choice is the physicians'.

The cause for free medicine in this country is in the hands of the Ohio State Medical Association.

Sincerely yours,
Gordon R. Meyerhoff, M. D.

Volunteers for Vietnam Program Field Director Is Named

Lawrence A. Smookler, M.D., San Francisco, Calif., has been named Field Director of the American Medical Association's Volunteer Physicians for Vietnam program.

The AMA administers the program, under contract, for the United States Agency for International Development (AID).

Plans called for Dr. Smookler to take up his duties in South Vietnam about September 1.

American volunteer physicians serve for two months in Vietnamese civilian hospitals throughout South Vietnam, principally in provincial towns. About 32 volunteers are in South Vietnam at all times, with 16 replaced every month. Volunteers receive only transportation expenses and a living allotment of \$10 a day.

Details may be obtained by writing to the AMA at 535 N. Dearborn Street, Chicago, Illinois 60610.

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Ohio Centers Participate in Coronary Drug Project

The Cardiac Laboratory of Cincinnati General Hospital is among 19 new centers enrolled under the Coronary Drug Project sponsored by the U.S. Public Health Service, and backed by grants totaling \$1,175,062. The additional 19 centers bring to 55 the total organizations participating in the large-scale clinical trial conducted by the National Heart Institute.

The Cincinnati project is headed by Dr. Ralph C. Scott and has been awarded a grant of \$70,403 for the first year.

Another participating organization is the Department of Preventive Medicine, University Hospitals, Cleveland. The project there is headed by Dr. Irving M. Liebow.

The project is directed toward determining whether drugs that lower blood levels of cholesterol and other fatty substances can improve long-term survival among heart-attack victims by protecting them against recurrent heart attacks and other complications of coronary heart disease.

The Project will eventually recruit a total of 8,500 patients. Those eligible are males, aged 30-64, who have survived one or more heart attacks by at least three months, who are free of other life-threatening diseases, and who will require neither anticoagulants nor insulin therapy while participating in the Study.

Patients already under the care of private physicians can be admitted only by referral by that physician or with his consent. The Project Clinics will cooperate closely with referring physicians and keep them fully informed of the current status of their patients.

Each clinic is allowed up to two years to recruit 150-160 volunteer patients toward the 8,500 total required to insure the validity of the Project findings. Recruitment is underway at those clinics whose participation began earlier and will shortly be underway at those most recently enrolled.

The patients will be followed at regularly scheduled intervals for a period of five years. All data and study forms will be forwarded for processing and analysis to the Coordinating Center, University of Maryland, Baltimore. All laboratory studies will be done through a PHS Laboratory at the Communicable Disease Center, Atlanta, Georgia; and all drugs stored and distributed from PHS Supply Service Center, Perry Point, Maryland.

The clinical phase of the Project will be completed by 1974. The total cost is estimated at \$35-40 million.

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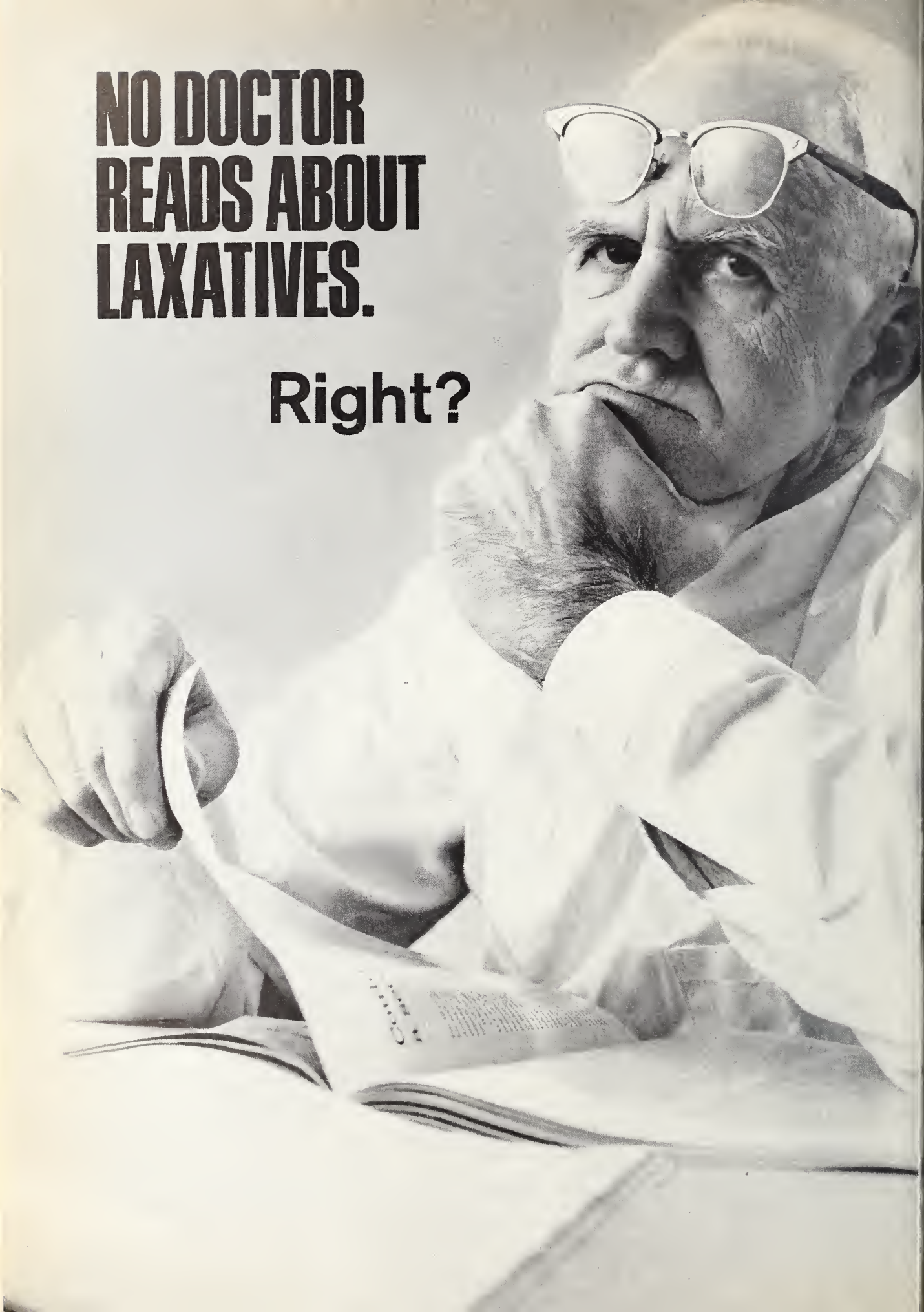
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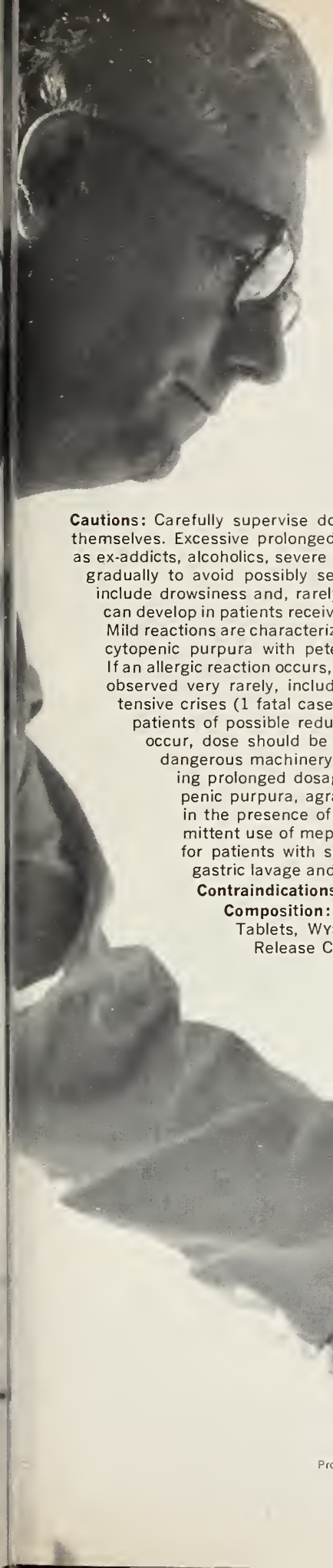
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Cincinnati Radiological Heritage

The First Fifteen Years

STANLEY LUCAS, M.D.*

PART IV

(Continued from August Issue)

1907 - 1910

CINCINNATI was reviewing articles from national journals concerning the therapeutic use of x-ray in conditions such as Hodgkin's disease, leukemia, sarcomas, and uterine carcinomas. Dr. Otto Juettner, a versatile individual, skilled in the fields of music (composer of many University of Cincinnati songs), medical history (author of *Daniel Drake and His Followers*, the classical and monumental work of the early history of medicine in Cincinnati), and medical science, wrote a book entitled *Modern Physiotherapy* and published by the Harvey Publishing Company of Cincinnati, Ohio. There was in this book devoted to x-ray diagnosis one chapter in which he clearly defined professional ethics for the practice of radiology.

Never do radiographic work unless it is to benefit some physician and through him some unfortunate patient. Give one or two copies of the x-ray picture to the physician for whom the work is done. If the patient is to get a picture, let his physician give it to him. Never pretend to interpret an x-ray picture to any patient. Interpret it to the doctor if he wishes it.

On October 3rd, 4th, and 5th, 1907, the American Roentgen Ray Society held its first Cincinnati meeting at the Grand Hotel on the southeast corner of Fourth and Central Avenues. Dr. Sidney Lange was the local Chairman of the exhibit dealing with the differential diagnosis of bone tumors, bone tuberculosis, osteomyelitis, and bone cysts.

The greatest undertaking of the American Roentgen Ray Society has been the suppression of Quackery. . . . The intelligent and able effort of this Society to suppress the false and to proclaim the true has been invaluable to the medical profession at large. . . . The x-ray was heralded as the ne plus ultra of scientific achievement. Enthusiastic devotees

without training and without the patience necessary to acquire it, installed costly apparatus. Then the inevitable disappointment ensued.

With the organization of the American Roentgen Ray Society, radiography was replaced in the confidence of medical men—as a means of diagnosis it has been found of superlative value, in its therapeutic application much is still wanting to render it efficacious—lately, however, a distinguished Cincinnati scientist (Dunham) has invented a meter by which dosage can be regulated, a consideration of immense importance.

At this meeting in Cincinnati, national speakers included such prominent people as Dr. Percy Brown, Dr. Lewis Gregory Cole, Dr. G. E. Pfahler, Dr. Henry Pancoast, and the President of the Society, Dr. P. M. Hickey. Two Cincinnatians spoke at this meeting, Dr. Albert H. Freiberg on a "Demonstration of Types of Arthritis" and Dr. Samuel Allen, a physicist, on "An X-Ray Unit Demonstrated by a Standardized Meter." Following the convention, a note in the local Journal indicates "a discouragingly small number of local physicians attended the superlatively important sessions of the American Roentgen Ray Society at the Grand Hotel the past week."

Dr. Dunham published in the *Cincinnati Lancet Clinic* a series of letters from leading radiographers on the details of developing, and the chemistry involved, in darkroom techniques. In December, 1907, Dr. Dunham continued to write on the importance of "Protection of Patient and Operators in X-Ray Work" and warned that the general medical public should not entrust their patients to those inexperienced in employing the x-rays safely and effectively. He also wrote a paper on "The Necessity of a Systematic Method of Teaching the Physics and Physiological Effects of the X-Ray and Its Application to Diagnosis and Treatment." In this paper, he noted

the newspapers have given the subject much attention—these accounts are inaccurate, but it is surprising that our medical press has not seen the necessity of protecting its

*Dr. Lucas, Cincinnati, is Radiologist, Jewish Hospital; Attending Radiologist, Cincinnati General Hospital; Assistant Clinical Professor of Radiology, The University of Cincinnati College of Medicine.

Submitted October 24, 1966.

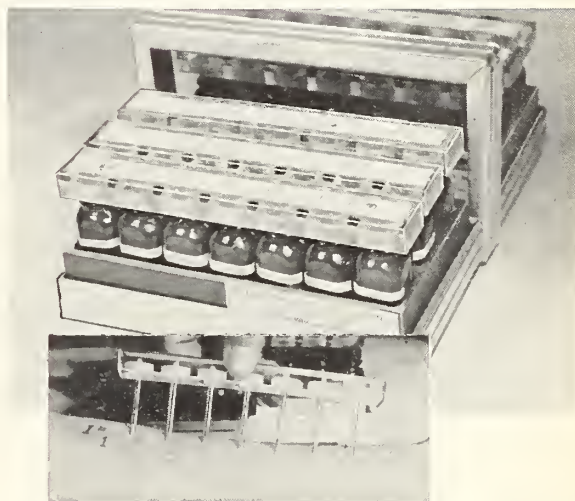
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readers from the dangers of such inaccurate observation. ... Not a single specialist or general practitioner can practice his art successfully without its aid.

He felt that x-ray should be taught in medical school and that they should start with the physics of electricity "which must be manipulated to secure the proper x-ray exposure or deliver an approximate dose." For the first time, the subject of radiography was being taught at the Medical College of Ohio in a series of 24 lectures, the first 12 on the physics of radiation and the second 12 on the method of taking exposures and reading the plates.

In 1908, only 13 years after the discovery of the ray, almost every dermatologist had an x-ray machine, but Dr. Dunham warned "x-ray, like colors, must be used with brains or the result will be a daub. And the Canvas of the radiotherapist is not so mute as that of the artist." In this year Dunham published an article in the *Cincinnati Lancet Clinic* on "The X-Ray in Incipient Tuberculosis," probably one of his first articles in the field of tuberculosis, for which he later became internationally known.

Dr. Sidney Lange, who had been appointed radiographer of the Cincinnati Hospital and of the Jewish Hospital in 1906, delivered a paper in January of 1907, on the present status of the roentgen ray. He noted "A skiagraph has no intrinsic value. It is worthless, even dangerous, unless in the hands of one able to correctly interpret." He gave a very complete and inclusive discussion on the physical properties of x-ray and its use in therapy and diagnosis. He also noted

Under no circumstances should the plate or a print be put in the hands of a patient, because of the readiness with which such evidence lends itself to unscrupulous criticism and litigation.

He noted that the static machine was now obsolete and that the tube of the future would be one of small size but with a heavy platinum target and a method of cooling the target. He noted the importance of cutting out secondary rays by using sheets of lead or compression cylinder diaphragms.

The important uses of x-rays at this time included studies for orthopedics, localization of foreign bodies, sinus diseases, dentistry, KUB calcifications, pelvimetry, chest problems, and esophagus and stomach after the feeding of a bismuth mixture. At this time, gallstones were not diagnosable by x-ray because of the low specific gravity of stones and the lack of detail on the film. Dr. Lange noted that "during the taking of a picture, the danger to the patient is practically nil, since with modern apparatus the length of exposure is so short" (!).

Dr. Lange reported the case of a female patient with a hairpin in the bladder, inserted in a mistaken effort to produce abortion. He also reported on fractures of the knee. Later in the year, Dr. Lange read a very comprehensive paper on "The X-Rays and Their Application to Dentistry." This was given before the Cincinnati Odontological Society in February, 1908. In this paper he says "I will readily

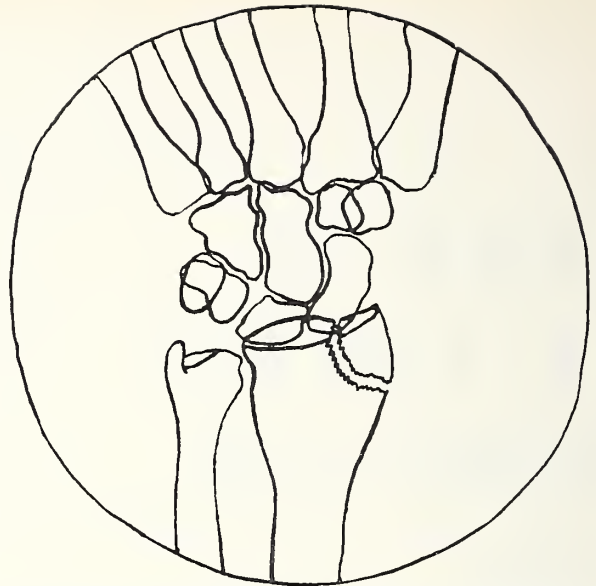


FIG. 6. "Automobile Fracture" — fracture of radial styloid process caused by recoil of automobile crank and described by Dr. Sidney Lange, 1908. The Cincinnati Lancet Clinic.

plead guilty to an excessive enthusiasm in this line of work, an enthusiasm which often routes conservatism." He read a paper before the West End Medical Society on "Aortic Aneurysm and the Mediastinum from the X-Ray Standpoint." He wrote about obscure fractures discovered by x-ray and an article entitled "The Automobile Fracture—A Fracture of the Lower-Outer Tip of the Radius Produced by the Recoil of an Automobile Crank" (Fig. 6), (A hazard of the horseless buggies).

Other subjects being written about included the importance of x-ray in the diagnosis of renal and ureteral calculi with a claim of accuracy in 90 per cent of the cases. The *Cincinnati Lancet Journal* reviewed articles by Dr. E. S. McKee on "The Use of the X-Ray to Induce Abortion" and quoted the statement of Dr. Hulst from the *New York Clinical Journal* "Good bone pictures are now so much the rule as to excite little interest beyond that of their clinical value." They reviewed a paper by Dr. J. T. Dunn of Louisville, Kentucky on the treatment of carcinoma of the breast by radical surgery followed by roentgen therapy "if done by competent people." A review also appeared on the paper of "Roentgen Ray in Pediatrics" by Dr. Thomas M. Rotch and Dr. W. A. George from the *Boston Medical and Surgical Journal*.

The benefits and dangers of x-ray continued to be debated. W. D. Haines, a Cincinnati surgeon, wrote on the surgical treatment of x-ray skin changes based primarily on early excision, skin grafting, and if necessary amputation. He stressed "Much evidence is gathering which shows the continued irritation of the x-ray will produce the very condition (cancer) which its use was claimed to cure."

(Concluded in October Issue)



Scientific Section

VOL. 63

SEPTEMBER, 1967

No. 9

Rehabilitation of the Amputee

The Role of The Ohio State University Prosthetic Clinic

GEORGE H. KRAFT, M.D., ERNEST W. JOHNSON, M.D., and MARVIN H. SPIEGEL, M.D.

FOLLOWING the amputation of an extremity, a patient is faced with many new problems, which may be unrelated to his basic disease. For example, if he has lost a hand, he will be unable to do routine tasks. The amputee may also feel mutilated and find interpersonal relationships embarrassing and difficult. Furthermore, it may be impossible for him to return to his job, and financial worries may be added to his other burdens.

Although many patients are able to return to their former lives after surgery, amputees often cannot. The amputee, his self concepts and his ability to function in the world about him have been altered. Therefore, rehabilitation must include attention to the whole person and his total environment.

The Ohio State University Prosthetic Clinic

In order to manage these complex medical and social problems, it is now widely accepted that specialized prosthetic clinics or centers should be established.¹⁻³ One such comprehensive prosthetic clinic was started in 1958 in the Department of Physical Medicine, at The Ohio State University College of Medicine. This clinic is made up of members from several disciplines and can advise the patient and referring physician on the medical, prosthetic, vocational, and social problems which may occur after an amputation.

The objectives of the Prosthetic Clinic are to provide physicians with consultation and prosthetic pre-

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scription and to recommend pre- and postprosthetic training for their amputee patients. Each patient's psycho-social-vocational needs, as well as his general health and condition of his extremity, determine the type of prosthesis recommended.

Clinic Structure

The Prosthetic Clinic has been in operation for the past eight years and is held every Friday afternoon at Dodd Hall, one of the Ohio State University hospitals. Since evaluation is comprehensive, the number of patients is limited to six or seven for each session. The Clinic comprises physicians, prosthetists, counselors from the Bureau of Vocational Rehabilitation, social workers and physical and occupational therapists. The medical staff consists of psychiatrists, an orthopedist, the medical administrative officer of

TABLE 1. *Patients with Multiple Amputations*

Disease	Patient	Age	Sex	Amputations*
<i>Trauma</i>	1	34	F	(L) AK, (R) BK
	2	45	M	(R) AK, (L) AE
	3	45	F	(R) AK, (L) BK
	4	49	M	(R) Transcarpal, (L) Transcarpal
	5	51	M	(L) Shoulder Disarticulation, (L) AK, (R) AE
<i>Diabetes</i>	6	55	M	(R) Symes, (L) Symes
	7	69	F	(R) BK, (L) BK
	8	71	M	(R) AK, (L) BK
	9	74	M	(R) AK, (L) BK
<i>Atherosclerosis</i>	10	61	M	(R) AK, (L) BK
	11	72	F	(R) AK, (L) AK
	12	75	F	(L) Symes, (R) BK
<i>Buerger's Disease</i>	13	31	M	(R) BK, (L) BK
	14	45	M	(R) AK, (L) AK
<i>Osteomyelitis</i>	15	25	M	(R) AK, (L) AK
	16	35	F	(L) Transmetatarsal, (R) Symes
<i>Burns</i>	17	33	M	(R) AK, (R) AE

* AK = above knee, BK = below knee, AE = above elbow.

TABLE 2. *Patients Admitted to a Rehabilitation Facility*

Patient	Age	Sex	Amputations*	Complicating Factors
1	25	M	(R) AK, (L) AK	Osteomyelitis, paraplegia
2	28	F	(R) AK	Osteogenic sarcoma
3	33	M	(R) AE, (R) AK	Burns
4	45	M	(R) AK, (L) BK	
5	45	M	(L) AE, (R) AK	
6	45	F	(R) AK, (L) BK	
7	40	M	(R) BK	
8	35	M	(L) BK	Painful stump, flexion contracture
9	51	M	(L) AK, (R) AE, (L) Shoulder Disarticulation	
10	53	F	(L) BK	Left hemiparesis
11	67	M	(R) BK	Hemiparesis
12	59	F	(R) BK, (L) BK	Deaf, blind, heart disease
13	70	F	(R) AK	Hip flexion contracture
14	70	M	(R) AK	
15	71	M	(L) AK	
16	76	M	(L) AK	Hip flexion contracture
17	78	M	(L) AK	

*AK=above knee, BK=below knee, AE=above elbow.

the Bureau of Vocational Rehabilitation, and resident physicians. Other interested physicians and medical students often attend.

Before being presented in the Clinic, each amputee is first examined by a Clinic physician. In addition, a social worker interviews the patient to obtain pertinent vocational and social information. The patient is then presented to the Clinic conference, where he is further evaluated with regard to his amputated extremity and his goals regarding use of an artificial limb. Following this, the patient's case is discussed in depth, and an estimate is made of his ability to use a prosthesis. Conference decisions are then discussed with the patient by the physician who made the initial examination.

If it is felt that a prosthesis is indicated, a detailed prosthetic prescription is written by the Clinic physicians. Often, however, the patient may not be ready for a prosthesis and further evaluation or pre-prosthetic treatment is necessary. For example, it may be recommended that the patient have physical therapy to reduce contractures. Or, if the patient's problems are more severe, he may be admitted as an



FIG. 1. This bilateral above knee amputee was admitted to the Rehabilitation Service of the Ohio State University Hospitals for training in the use of his new prostheses. Learning to walk with bilateral above knee prostheses requires intensive training, and is best carried out on an in-patient basis.

SEX DISTRIBUTION

103 AMPUTEES

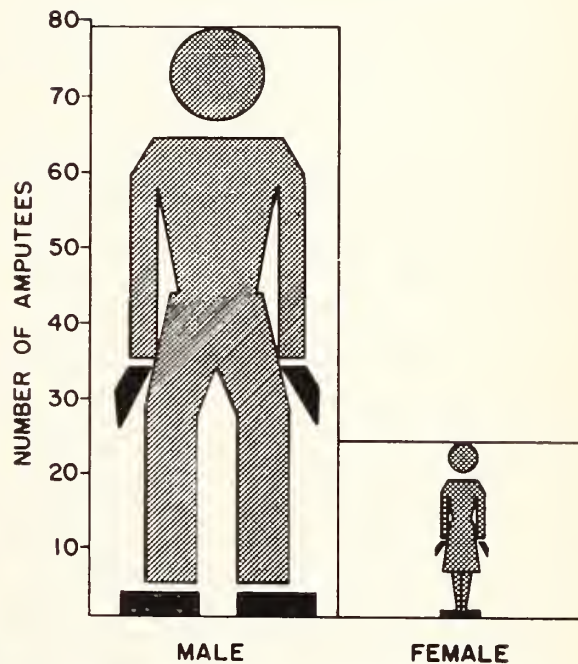


FIG. 2. Of the 103 amputees seen in the Ohio State University Prosthetic Clinic between July 1, 1965 and July 1, 1966, 79 were males and 24 were females.

AGE DISTRIBUTION

103 AMPUTEES

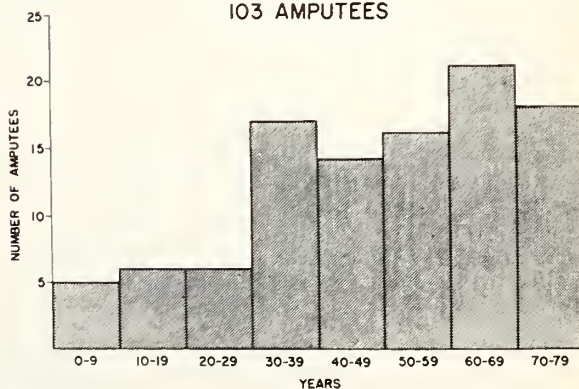


FIG. 3. Most amputees evaluated were at least 30 years old. The largest number seen was in the seventh decade, with 21 patients evaluated.

inpatient where his preprosthetic treatment program can be carried on more intensively.

After the patient has received his prosthesis, he is re-evaluated in the Clinic and appropriate post-prosthetic training is recommended. Generally two weeks of gait training are needed for optional use of an above knee prosthesis. However, only a few sessions are needed to obtain an excellent gait with a below knee prosthesis. For upper extremity prosthetic training, from two to three weeks are required. The training may be done wherever medically supervised and licensed physical and occupational therapists are available.

Following the training period and after the patient has adjusted to his prosthesis, he is again seen in the Clinic for the final "checkout." At this session the amputee's use of his prosthesis is evaluated with relation to initial expectations and his demonstrated ability.

Services Offered by the Prosthetic Clinic

The services of the Prosthetic Clinic are available to any physician. Over 100 patients are evaluated and managed each year. Depending upon the request of the referring physician, the Clinic may take full care of the patient's prosthetic needs, prescribe a prosthesis, or simply give an opinion regarding an amputee or a prosthetic problem. Often the physician prefers for the Clinic to manage the entire amputee rehabilitation program. If this is his choice, the referring physician is advised of the patient's progress by Clinic progress reports.

Frequently, there are medical problems which must be controlled before the prosthesis can be ordered. Flexion contractures, stump ulcerations and

TABLE 3. Source of Referral

Private Physicians	32
Ohio State University Clinics	31
Bureau of Vocational Rehabilitation	22
Prosthetists	12
Miscellaneous	6
Total	103

edema, incoordination, and weakness must all be corrected before the patient is able to use a prosthesis. If it is desired by the referring physician, the patient can also receive vocational evaluation.

Patients Evaluated Over a 12 Month Period

One hundred and three amputees were seen in the Ohio State University Prosthetic Clinic between July 1, 1965 and July 1, 1966. These patients are a representative cross section of amputees seen in the United States as shown by comparison with 12,000 amputees recently surveyed by the National Academy of Science—National Research Council.⁴ There were three times as many men as women (Fig. 2). Most of the amputees (Fig. 3) were between the ages of 30 and 79, with the peak incidence occurring during the seventh decade. In all age groups, there were consistently more men than women.

Of the 103 patients evaluated, 64 were new referrals and 39 were patients who had been referred previously and were being followed through their preprosthetic treatment or prosthetic training. The majority of new patients were seen either two or three times in the Clinic.

The 103 patients had 119 amputations (Figs. 4 and 5). Eighty-four patients had a single amputation,

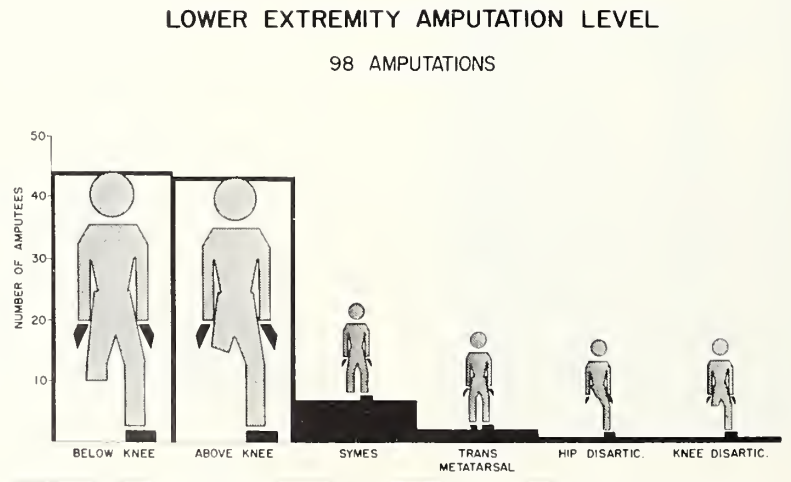


FIG. 4. Below knee and above knee amputations were the most frequent lower extremity amputations seen. Other lower extremity amputations evaluated were Symes, transmetatarsal, hip disarticulation, and knee disarticulation.

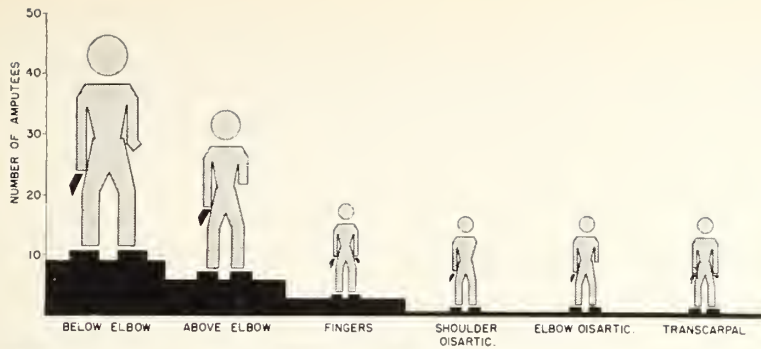


FIG. 5. The most common upper extremity amputation evaluated was below the elbow, with nine seen. Other upper extremity amputations were above elbow, fingers, shoulder disarticulation, elbow disarticulation and transcarpal.

UNDERLYING DISORDERS

103 AMPUTEES

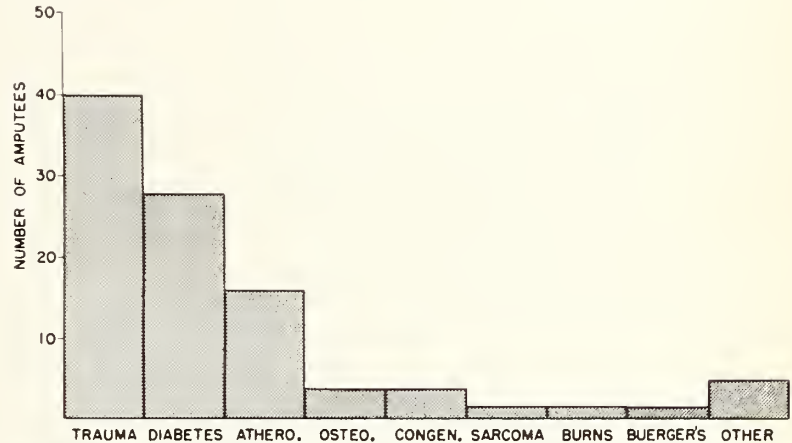


FIG. 6. Trauma was responsible for the largest number of amputations, with 40 patients having amputations as the result of injuries. Diabetic vascular disease was responsible for amputations in 28 patients, and atherosclerosis was the underlying cause in 16. Other disease conditions were osteomyelitis, congenital amputation, osteogenic sarcoma and Buerger's disease.

16 patients had double amputations, and one patient was a triple amputee. Eighty-two per cent of the amputations involved a lower extremity. Most of these were either above knee or below knee, with other lower extremity amputations uncommon.

Vascular disease and trauma were responsible for amputations in 85 per cent of the patients. Vascular disease comprised the larger group, accounting for amputations in 46 patients, while 43 patients had amputations as a direct result of trauma to an extremity. Other disease conditions (Fig. 6) responsible for amputations included chronic osteomyelitis and osteogenic sarcoma. Of the 17 patients having multiple amputations (Table 1) the majority involving

the lower extremities were caused by vascular disease. However, all of the multiple amputations involving an upper extremity were due to trauma.

Eighty-two prostheses were ordered for 75 patients, with 68 single amputees and 7 multiple amputees receiving prescriptions.

Seventeen patients (Table 2) presented problems that could not be managed adequately on an outpatient basis, and they were scheduled for admission to a rehabilitation facility. The indications for admission were: (1) complicating medical conditions such as blindness, hemiplegia, or paraplegia; (2) severe flexion contractures or stump pain; and (3) multiple major amputations. However, the typical

referral was less complex. The average unilateral below knee amputee was evaluated and given a prescription on his first visit. It then took about two weeks to make the limb, and several training sessions for the patient to become adept in its use. Usually about a month after his initial visit, the amputee received his final "checkout" from the Clinic.

Most patients were referred from private physicians throughout Ohio. A large number were also referred from the Ohio State University clinics, the Bureau of Vocational Rehabilitation, prosthetists, and other sources (Table 3).

Illustrative Case Report

A 61-year-old male machine operator with long-standing aorto-iliac atherosclerosis had a left above knee amputation October 17, 1965, because of gangrenous changes in his foot. On December 3 he was first seen in the Prosthetic Clinic, where he was found to have a hip flexion contracture (40°) and edema of the stump, with an unhealed incision. The patient and his wife were taught a home exercise and stump wrapping program, and he received crutch training as an outpatient. On February 25, when seen again in Clinic, his hip contracture was 15°, there was no stump edema, the incision was well-healed and he had a safe crutch gait. An above knee prosthesis with a

quadrilateral closed socket, suction suspension, friction lock knee, and solid ankle cushion heel foot was prescribed. The patient was referred to the Bureau of Vocational Rehabilitation for their assistance in the total rehabilitation program. He received the limb in late March and, after two weeks of gait training was re-evaluated in the Clinic. At that time, he walked well but needed several minor prosthetic adjustments. These were made and he returned to his job full time in late May, 1966.

Summary

The Ohio State University Hospitals provide comprehensive prosthetic services organized as a clinic in the Clinical Division of Physical Medicine and Rehabilitation. This Clinic, now centered at Dodd Hall, offers consultation on amputee and prosthetic problems facing the practicing physician. One hundred and three patients attended the Clinic in the past 12 months.

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SPEED LISTENING. — Blind people can be trained to understand tape recorded voices when played back at twice the recorded speed. Modifications of conversational recorders developed recently by Medical Electronics Research Institute in Phoenix, Arizona, under contract with the Public Health Service's National Center for Chronic Disease Control, offer promise of doubling the audio "reading" speed of the visually handicapped.

According to Dr. John W. Hudson, blind Professor of Sociology at Arizona State University in Tempe, who directed the recorder improvements, understanding of the speeded-up speech can be frustrating to beginners. However, he claims that with continued training and experimentation with gradually increased voice playback speed, complete understanding can be achieved. Dr. Hudson taught himself to understand speech played back at two and one-half times the original recorded speed.

The significance of continued research into the potential of "speed listening" is accentuated when compared with the "reading" time required by other methods available to the blind. For example, the average Braille reading rate for blind high school students is 90 words per minute as compared to an average rate of approximately 251 words for sighted high school students. In one approach to the solution of this problem, educators have increasingly used recordings in the education of blind students. By this means, "reading" by ear can proceed at about two-thirds the rate that is typical for sighted high school readers. "Talking books," the recorded concept now extensively used, have proven to be of tremendous assistance. It is believed that this speeded-up listening method offers even better means of learning acceleration.

Speeded-up listening is not to be confused with "compressed speech" where the person voicing the material being recorded speaks as rapidly as possible. Compressed speech approaches being studied are also promising. However, Dr. Hudson declares that the necessary equipment is very expensive and not readily available. The "speed-listening" approach developed by Dr. Hudson involves techniques, materials, and equipment which are both inexpensive and readily available at the present time. — U. S. Dept. Health, Education, and Welfare Public Health Service, Arlington, Va., *News Release*, July 19, 1967.

Cold Agglutinin Positive Pneumonia

A Review of Thirty Cases In Children

DAVID D. THOMBS, M.D.

CHILDREN with apparently routine pneumonia that fails to respond to penicillin present a difficult diagnostic problem to the physician. Some of these "atypical" pneumonias will be associated with high cold agglutinin titers and the majority of these can be classified as primary atypical pneumonia due to *Mycoplasma pneumoniae* (Eaton agent).¹ The importance of Eaton agent lower respiratory disease in children has recently been emphasized in a study from Seattle where it is estimated that 17 per cent of the pneumonia in the 5-9 year age group and 31 per cent of the pneumonia in the 10-19 year age group is caused by *M. pneumoniae*.² Excellent reviews of Eaton agent pneumonia have appeared in the literature concerning largely adult populations.³⁻⁶ It is the purpose of this paper to summarize the clinical picture seen in 30 children admitted to the Cincinnati Children's Hospital in 1965 with pneumonia and high cold agglutinin titers.

Materials and Methods

The laboratory records of children age 15 and under, hospitalized between July 1 and mid-December 1965 were reviewed for positive cold agglutinins as determined by a modification of the technique described by Finland.⁷ A titer of 1:64 or greater was considered as a significant positive single titer. The charts of those patients with cold agglutinin titers of 1:64 or greater were reviewed and only those children with pneumonia by x-ray or physical examination were selected for further study. The selected group was then analyzed for possible predisposing factors, general clinical picture on admission to the hospital, associated laboratory data, x-ray findings, hospital course, and possible complications. No attempts were made to isolate *M. pneumoniae* or to examine paired sera for evidence of mycoplasma infection in this group.

Results

Thirty children with pneumonia and high cold agglutinin titers were found. Three children had fourfold rises in titer to 1:128-1:256 during their illness. The remaining 27 had single cold agglutinin determinations performed. Seven of these had titers of 1:64, seven had 1:128 titers, 10 had 1:256

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titers, and three had 1:512 titers. The distribution by age included four children ages 0-4 years, 11 children 5-8 years, 12 children 9-12 years, and three children ages 13-15 years. Nineteen children were admitted in the months of October and November, the remainder being approximately evenly distributed through the other four months. There were 14 boys and 16 girls.

Predisposing Factors

The 30 cases were analyzed for possible predisposing factors and 12 had a history which could be viewed in this way (Table 1). Four children had allergic histories; two of these were overt asthmatics and two were on desensitization programs. Two

TABLE 1. Possible Predisposing Factors
(12 of 30 Patients)

History of Allergy	4
History of Chronic or Serious Infection	3
(a) Meningitis	1
(b) Recurrent Pneumonia	1
(c) Chronic Pyelonephritis	1
Recent Conversion of T. B. Skin Test	2
Prematurity	2
Acute Lymphocytic Leukemia	1
Mongolism	1

children had converted their tuberculin skin tests to positive within two months prior to hospitalization. One had acute lymphocytic leukemia in remission and was on 6 mercaptopurine but not steroids, and three children had a history of chronic or serious infection in the past.

Clinical Picture

A typical case is presented below:

A 4-9/12 year old white girl was admitted late in October 1965 with a 9 day history of fever in the range of 101-102° F and persistent vomiting. The child had begun

Submitted December 21, 1966.

coughing five days prior to admission and was treated with a penicillin and sulfonamide combination. Symptomatic therapy for vomiting was ineffective and she was admitted to Children's Hospital. Physical examination revealed an acutely ill, dehydrated child with a temperature of 99.4° F, pulse rate 100 per minute, respiratory rate 25 per minute. There was mild rhinorrhea, questionable injection of the right tympanic membrane and a moderately red throat. Moist rales and diminished breath sounds were heard over the right lower lobe and the remainder of the physical examination was unremarkable.

Admission laboratory data: White blood cell count 9,150 with a shift to the left. Hemoglobin was 11.0 Gm. per 100 ml. Chest film showed bilateral bronchopneumonia with nodular infiltrates and questionable fluid or pleural thickening at the costophrenic angles (similar to the x-ray in Fig. 2). A cold agglutinin titer was 1:512. PPD and histoplasmin skin tests were negative, a nasopharyngeal culture grew *Staphylococcus epidermis*, and a sweat chloride was 39.8 mEq/liter.

The child was started on treatment with penicillin and intravenous fluids but failed to improve during the first 48 hours, the temperature rising to 102° F. Following institution of tetracycline after 48 hours of hospitalization, the child had a course characterized by gradually decreasing fever over the next five days, persisting rales, and the emergence of a loose, productive cough with evidence of gradual clearing of infiltrates by x-ray on day three. On the eighth hospital day she was symptomatically well but had persistent rhonchi in both lung fields.

That the majority of the children presented with a history of a lingering pneumonitis apparently unresponsive to antibiotics is documented in Table 2. Over three fourths of the children had complaints

TABLE 2. Duration of Illness

Less than 1 week	7 (23%)
1 - 2 weeks	10 (33%)
2 - 3 weeks	6 (20%)
3 - 4 weeks	4 (13%)
4 or more weeks	3 (10%)
Pre-Treatment With Antibiotics	
Penicillin (PCN)	15 (50%)
PCN + Unknown	3 (10%)
PCN + Tetracycline	2 (7%)
PCN + Sulfa	1 (3%)
PCN + Sulfa + Erythromycin	1 (3%)
Tetracycline alone	1 (3%)
Unknown Treatment	3 (10%)
No Treatment	4 (13%)

for more than a week and 10 per cent had an illness of greater than a month's duration. At least 22 of them failed to respond to penicillin and were, therefore, hospitalized. The children who received tetracycline and erythromycin were given these drugs late in their course prior to hospitalization. Four children received no antibiotics before admission, and in three the presence of pneumonia was unsuspected prior to x-ray examination.

The presenting symptoms are listed in Fig. 1 and show a predominance of cough and fever, but also an impressive array of non-respiratory symptoms

SYMPTOMS OF COLD AGGLUTININ POSITIVE PNEUMONIA IN CHILDREN

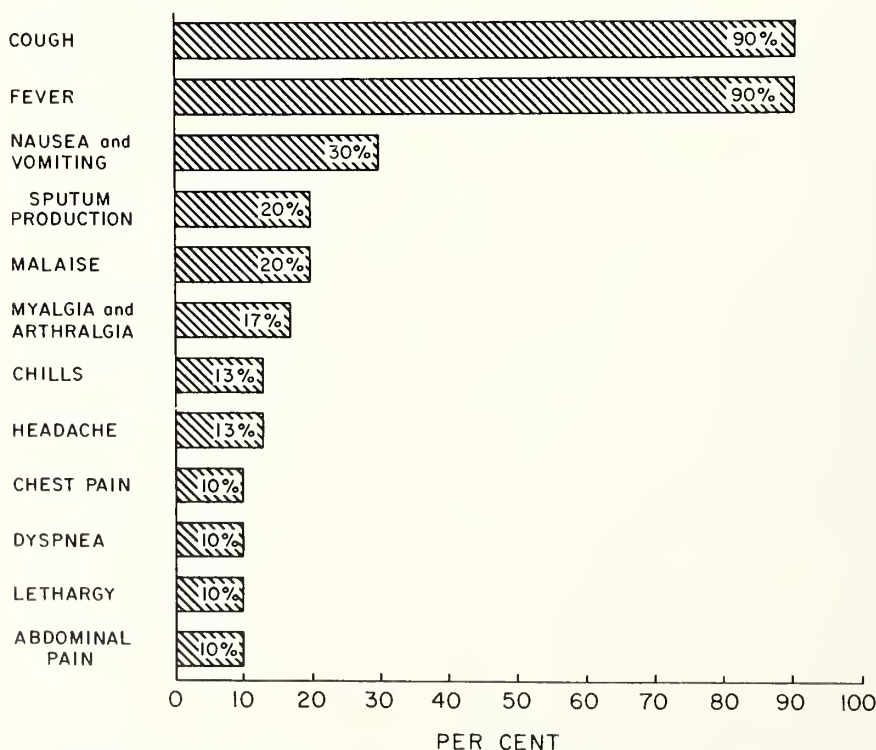


FIG. 1. Clinical symptoms of 30 children with cold agglutinin positive pneumonia expressed as per cent of children manifesting the complaint.

such as nausea and vomiting, myalgia and arthralgia, malaise, and headache. The signs shown in Table 3 emphasize the predominance of pulmonary findings. It was noted that many of the patients did not have rales on admission but these were heard on subsequent physical examination. Only 10 per

TABLE 3. *Signs*

Respiratory	%	Other	%
Rales	73	Splenomegaly	17
Pharyngitis	33	Lymphadenopathy	13
Otitis	27	Conjunctivitis	10
Rhonchi	20	Petechiae	7
Dim. Breath Sounds	17	Hepatomegaly	7
Dullness	13	Nuchal Rigidity	7
Wheezes	10	Herpes Simplex	3
Tubular Breath Sds	7	Abdominal Tenderness	3
Rhinorrhea	3		
Negative	10		

cent had a normal physical examination on admission, these being the three children with previously unsuspected pneumonia found by x-ray.

Laboratory Data

Routine laboratory work is partially summarized in Table 4. Admission white blood cell counts ranged from moderate leukopenias to marked leukocytoses. White counts fell or remained normal after admission. Differential counts generally showed a

TABLE 4. *Routine Blood Work*

Admission WBC (1st 36 Hrs)	% Polys (1st 36 Hrs)		Eosinophils	
No. Pts.	No. Pts.		No. Pts.	
Less than 5,000	2	50%	4	0%
5,000 - 10,000	13	60%	6	1 - 4%
10,000 - 15,000	7	70%	10	5 - 8%
15,000 - 20,000	5	80%	10	9 - 12%
20,000 - 30,000	2	90%	0	
30,000 - 40,000	0			
40,000 - 50,000	1			

predominance of polymorphonuclear leukocytes, and, during the hospitalization, there was a tendency for eosinophils to appear on the smear, 7 of 30 showing greater than 5 per cent eosinophilia. Urinalyses were normal or demonstrated a transient albuminuria that cleared with recovery. Out of 39 reported cultures related to the respiratory track, pneumococci were reported in nine cultures but in none was there a definite predominant growth of pneumococci. Several other pathogens were reported, including one culture with coagulase positive staphylococci, two cultures with *Haemophilus influenzae*, and one culture with group A beta hemolytic streptococci.

X-Ray Findings

Chest x-rays were reviewed on 29 children revealing a wide variety of roentgenologic findings. Generally, the experience can be summarized by the

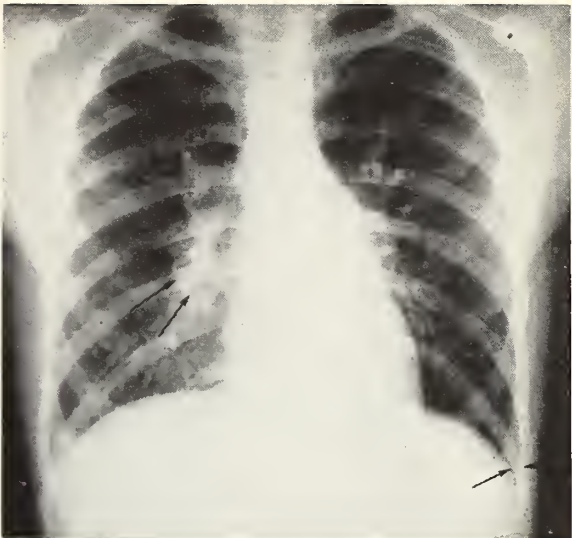


Fig. 2. (PA Chest)



Fig. 2. (Lateral Chest)

FIG. 2. Admission PA and lateral of the chest showing bronchopneumonia, hilar adenopathy, and pleural fluid or reaction.

x-ray findings in two patients whose admission films are shown in Figures 2 and 3. The findings in Figure 2 were seen in the largest portion of the patients in the series. There is a bilateral bronchopneumonia primarily involving the lower lobes; accentuation of the normal bronchovascular markings, and fine nodular infiltrates visible most easily at the periphery. At the left costophrenic angle there is evidence of either pleural thickening or pleural effusion, and finally, the picture of hilar adenopathy is seen. Figure 3 shows a strikingly different

picture presenting as a dense consolidation and atelectasis of the right upper lobe.

A tabulation of these findings is summarized in Table 5 showing the majority (21) to have the x-ray findings of bronchopneumonia. Five children had evidence of consolidation or atelectasis, and three had negative chest films but physical findings of rales or wheezes.

Course

Generally, the child with cold agglutinin positive pneumonia was not extremely ill on admission, im-

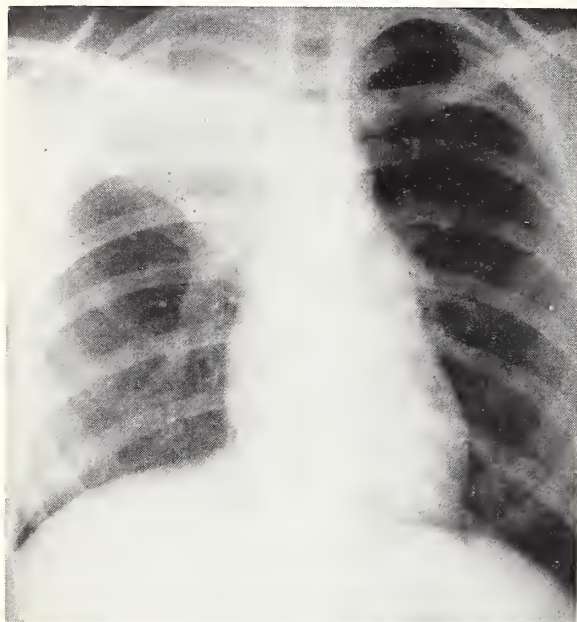


Fig. 3. (PA Chest)

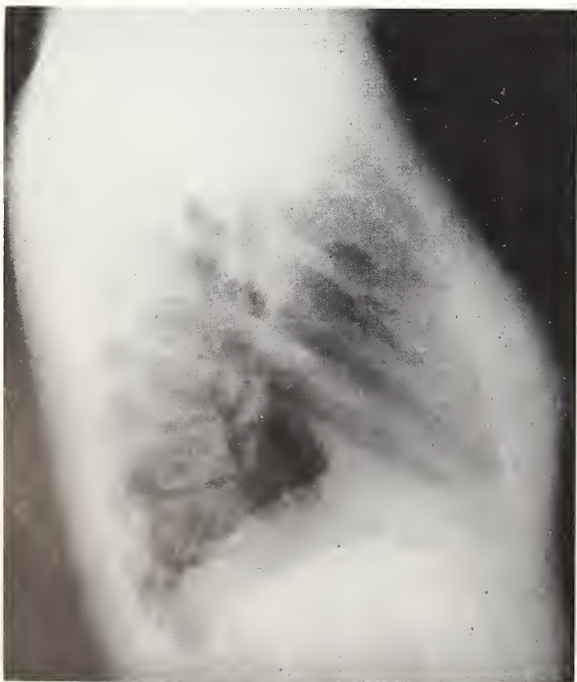


Fig. 3. (Lateral Chest)

FIG. 3. Admission PA and lateral of the chest showing consolidation and atelectasis of the right upper lobe.

TABLE 5. X-Ray Findings (29 Cases)

A. Predominant Picture	
1. Bronchopneumonia	21
2. Consolidation and/or Atelectasis	5
3. Negative	3
B. Other Findings	
1. Hilar Adenopathy	8
2. Pleural Reaction vs Effusion	8

proved significantly within a few days of hospitalization, and was discharged after a benign hospital course. The average length of hospitalization was 7.3 days with the average duration of fever greater than 100° F for 4.1 days, if febrile on admission. Nine children were afebrile throughout their hospitalization. Only five children appeared to be toxic or in significant respiratory distress on admission and their course did not vary significantly from the average child.

In five of the children, rales and wheezes persisted for several days after they were afebrile and felt well. Similarly, x-ray findings were slow to resolve. Twenty follow-up chest x-rays were taken and only one child's x-ray was normal within a week of the original film. The majority were markedly improved with almost complete resolution of infiltrates by the third week after hospitalization, but one child had significant infiltrate after one month.

Treatment

Nineteen of the children received tetracycline sometime during the hospitalization. Evaluation of therapy is impossible in a retrospective study of this type, however.

Complications

Complications in this series may be divided into two types, cardiac and hematologic.

CARDIAC. Three of the children had EKGs taken. One was an 8 year old with fever, arthralgia relieved by salicylates, an elevated erythrocyte sedimentation rate, an ASO titer of 500 Todd units, and the usual cough and rales. Rheumatic fever was considered. An electrocardiogram taken on the third hospital day, shown in Figure 4, suggested pericardial involvement. A repeat electrocardiogram on the sixth hospital day was normal. Similarly, both of the other children with electrocardiograms showed "nonspecific T Wave changes"; however, the children did well, and no follow-up electrocardiograms were made.

HEMATOLOGIC. A second type of complication was noted in an 8 year old boy admitted with malaise, cough, joint pain, pallor, splenomegaly, and rales. Admission hemoglobin was 6.9 Gm. per 100 ml. Subsequent studies noted thrombocytopenia, normal red cell indices, marked reticulocytosis, absent haptoglobin, elevated bilirubin, and an increased 24

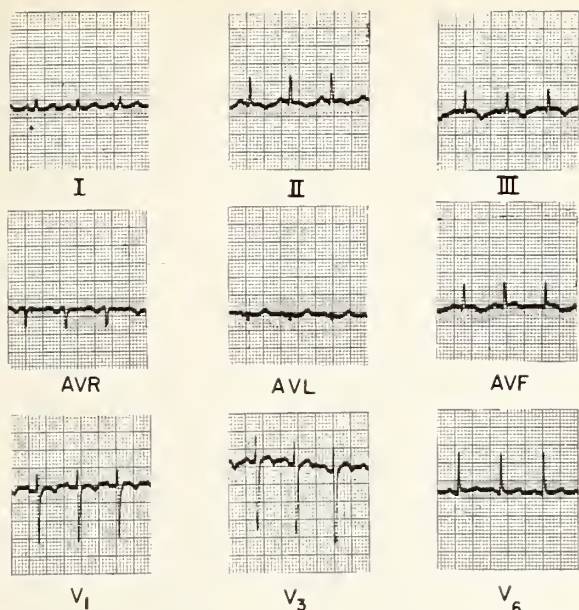


FIG. 4A—(October 25, 1965). *Electrocardiogram two days after admission showing T wave inversion in leads II, III and AVF and flattening of TV₆.*

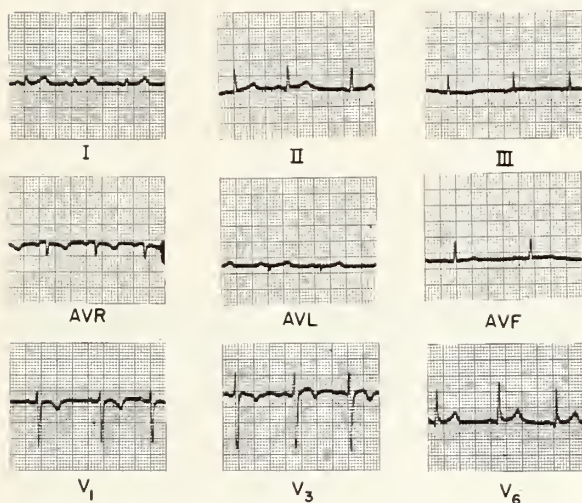


FIG. 4B (October 29, 1965). *Electrocardiogram on sixth hospital day. T waves are now upright in II, III and AVF. TV₆ is normal.*

hour stool urobilinogen. The bone marrow showed myeloid and erythroid hyperplasia. After a brief course of penicillin, a cold agglutinin titer was found to be 1:128 and subsequently 1:256. Direct and indirect Coombs' tests were positive at cold temperatures. He received blood transfusions, later developed a reticulocytosis of 40 per cent and made an excellent recovery from his initial hemolytic episode and pneumonia while being treated with tetracycline.

After several months, however, he was readmitted with a hemoglobin of 9 Gm. per 100 ml., moderate

reticulocytosis, an insignificant cold agglutinin titer, and a negative direct and indirect Coombs' test at cold temperatures. An extensive diagnostic evaluation for systemic disease, intrinsic red cell abnormalities, and autoimmune disease was nonrevealing. The child's hemoglobin returned to normal after a few weeks without treatment, although mild reticulocytosis persisted.

Discussion

Although the cold agglutinin test is nonspecific, it remains the only practical way to diagnose primary atypical pneumonia in childhood. Young⁸ lists 39 causes of positive cold agglutinin titers, but the vast majority of these do not fit the clinical picture of an atypical pneumonia and do not have high cold agglutinin titers. Rarely, pneumococcal pneumonia with sepsis and active tuberculosis may stimulate cold agglutinin titers as high as 1:64 or 1:128. Young implies, however, that demonstrating a fourfold rise in titer further classifies the patient, eliminating even these rare possibilities where the titer tends to be stable. A clinical picture of atypical pneumonia entirely indistinguishable from Eaton agent pneumonia has been shown to be due to adenoviruses and other agents in Marine recruits.⁹ A small percentage of these patients demonstrated significant cold agglutinin titer rises and, therefore, viral pneumonia due to adenoviruses cannot be excluded on the basis of a positive cold agglutinin titer.

On the other hand, the specificity of a positive cold agglutinin titer may be greater for children than adults as suggested by Grayston, et al¹ who observed that 88 per cent of patients under age 20 with acute respiratory disease and a high cold agglutinin titer (1:256 or greater) were either isolation or complement fixation positive for Eaton agent. Only 60 per cent of a similar group over age 20 had proven Eaton agent disease.

This group of hospitalized children with cold agglutinin positive pneumonia presents a picture of a child moderately sick with pneumonia whose respiratory symptoms may at times appear as only part of a systemic illness with fever, malaise, vomiting, and headache often of more than a week's duration. The diagnosis of primary atypical pneumonia is entertained usually because of the child's failure to respond to adequate treatment with penicillin. Routine blood work and cultures are not helpful. The chest films are indistinguishable from bronchopneumonia or lobar pneumonia caused by other agents, and the only readily available useful study to help differentiate an etiology is the cold agglutinin titer.

Once the diagnosis was made, the children were noted to improve on treatment with tetracycline. Although no conclusions about the effectiveness of antibiotics can be made from the present series, the

controlled double-blind study employing demethyl-chlortetracycline by Kingston, et al.¹⁰ has established the usefulness of this family of drugs in decreasing the morbidity of the disease and arresting progression of the pneumonia as seen by x-ray.

A variety of possible predisposing factors to infection with *M. pneumoniae* were found in the 30 cases reviewed in this study; however, no significance can be assigned to these presently. Children with chronic illnesses are more likely to be hospitalized with any acute illness possibly explaining the high incidence of "predisposing" factors in this series. Baernstein¹¹ suggests the presence of left-to-right intracardiac shunts is associated with severe infections with mycoplasma and is presently investigating the possibility of predisposition in Down's syndrome. More information needs to be gathered to know if children with primary atypical pneumonia need investigation for underlying disease.

The finding of electrocardiographic changes suggesting pericarditis has not been reported in children previously. Painton, Hicks, and Hantman¹² reviewed a large series of patients with a clinical picture of atypical pneumonia. Sixty-three of the 512 patients had serial electrocardiograms and 12 of these had evidence of myocarditis or pericarditis. These authors point out that electrocardiographic changes of pericarditis have long been known to occur in pneumococcal lobar pneumonia and conceivably pericarditis could be secondary to any inflammatory process in the proximity of the pericardium. The possibility that myocarditis or pericarditis are more specific complications in primary atypical pneumonia must also be considered. More recent publications noting this presumed association include a 20 year old woman with proven *M. pneumoniae* infection and transient pericarditis reported by Grayston,¹ and a death due to myocardial fibrosis secondary to myocarditis following an atypical pneumonia with a cold agglutinin titer of 1:2048.¹³

Hemolytic anemia following atypical pneumonias is a well known phenomenon and is summarized by Dacie.¹⁴ This typically late complication in a patient convalescent from pneumonia is usually associated with extremely high cold agglutinin titers not seen in this patient. In addition, the fact that hemolysis recurred unassociated with a positive cold agglutinin titer tends to discredit the atypical pneumonia as the primary event in the hemolytic episodes in this child. One is tempted to speculate that the peroxide hemolysin¹⁵ of *Mycoplasma pneumoniae* has altered the surface of the red cell stimulating antibody production which was not measurable by techniques used in this patient. The recurrent nature of the hemolysis in the absence of a high cold agglutinin titer would be explained by this hypothesis.

Summary

Thirty children with pneumonia and high cold agglutinin titers are reviewed, assuming the majority have primary atypical pneumonia due to Eaton agent. The children generally presented with a lingering respiratory disease despite treatment with penicillin and had a variety of constitutional and gastrointestinal symptoms in addition to their respiratory complaints. Physical examination usually yielded the diagnosis of pneumonia; however, a few children had unsuspected pneumonia found by x-ray. The usual laboratory aids did not serve to distinguish the primary atypical pneumonia from other pneumonias. X-ray examination of the chest showed a wide range of findings from broncho pneumonia to gross consolidation. Several children also had hilar adenopathy and pleural fluid or reaction. The majority of the children recovered in one to two weeks with relatively slow resolution of physical findings and infiltrates as seen by x-ray. While the pneumonia appeared uncomplicated in the majority of the children, three children proved to have abnormal electrocardiograms, and one child had an episode of hemolytic anemia.

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Aneurysm of the Brachial Artery

Case Report of an Unusual Pathogenesis

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IN CONTRADISTINCTION to the lower extremity, aneurysmal disease of the vascular tree of the upper extremity is more commonly the result of trauma and is consequently rare in the peacetime population. Arteriosclerosis is the common etiologic factor in the leg vessels. In order for trauma to produce arterial dilatation there must be either a weakening of the wall of the artery or a disruption of its integrity with the production of a pseudo-aneurysmal sac. The vascular tree of the arm is vulnerable to both direct injury and indirect injury, the former results from some external force and the latter from a stretching force. The indirect injury is particularly applicable to the first portion of the brachial artery as it emerges from the axilla.

Regardless of etiology a common complication of any arterial aneurysm is the formation of intraluminal thrombus that is subject to the forces of the vascular

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extremity complicated by a sudden arterial insufficiency of the hand.

Case Report

A 22-year-old white man was brought to the Emergency Room a few minutes after experiencing the sudden onset of pain, numbness, paresthesia, coldness, and paralysis of the left hand and fingers. Approximately one month prior to admission he had experienced a similar episode, but to a lesser degree. Approximately 18 months before this admission he accidentally impaled his left hand in a printing press machine suffering minor trauma to the involved hand and wrist. In an attempt to free his hand the patient exerted a sudden opposite force on the arm by a withdrawing mechanism resulting from the shift of the weight of his trunk and contraction of the shoulder girdle muscles. The result was a hyperextension and stretching of the arm at the shoulder. Shortly thereafter he noticed a prominent pulsation in the upper arm, but at no time did he note ecchymosis, swelling, or tenderness over the area.

Physical examination at the time of admission demonstrated a pulsatile mass measuring 3 to 4 cm. in diameter on the medial aspect of the upper left arm. The hand was cold, blue, and without radial or ulnar pulsations. The diagnosis of an aneurysm of the left brachial artery with peripheral embolization was made, and the patient was taken to surgery.

An arteriogram through the operative incision in the upper arm and axilla revealed an aneurysmal dilatation measuring 3 by 3 by 5 cm. in the first portion of the brachial artery and complete occlusion of the distal brachial artery just proximal to the antecubital fossa. (See Fig. 1.) The brachial artery both proximal and distal to the abnormalities described was normal, with the exception of a hypertrophied ulnar collateral branch at the elbow. Further surgical exploration revealed that the brachial artery at the antecubital fossa was completely occluded with an old fibrotic scarlike material, the obvious result of previous embolization. This same process extended into the proximal radial and ulnar arteries.

A direct surgical attack on the aneurysm was undertaken. It was completely excised and continuity was restored by means of a 5 cm. reversed greater saphenous vein graft using a running 5-0 silk arterial suture.

Postoperatively the hand was warm with a marked reactive hyperemia and good venous filling. Forty-eight hours



FIG. 1. Arteriogram performed during surgery showing aneurysmal dilatation of the brachial artery with complete occlusion of the distal brachial artery and hypertrophy of the ulnar collateral branch.

system resulting in peripheral embolization. The latter produces either a gradual or sudden state of arterial insufficiency distal to the embolic site. The subject of this report concerns a case of an aneurysm of the first portion of the brachial artery resulting from a previous stretch injury to the left upper

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later the radial and ulnar pulses were strong. The patient was discharged on his seventh postoperative day with normal function restored to the left hand. He was further able to return to heavy work five weeks later with no apparent disability in the upper extremity. Eight months later, an outpatient arteriogram was obtained via a retrograde catheter threaded into the aortic arch and left subclavian artery via the right femoral artery. (See Fig. 2.) Normal patency and healing of the vein graft were demonstrated.

Discussion

Other mechanisms of aneurysmal production in the upper extremity include penetrating wounds, contusions, including those associated with fractures and dislocations, arteriosclerosis, and mycotic aneurysm.^{1,2} The case under discussion had no history or evidence of direct trauma to the arm and there was certainly no associated fracture. Arteriosclerosis in a 22 year old would be extremely rare and has been further ruled out on the basis of microscopic examination of the aneurysm itself. By the same means a mycotic aneurysm has been eliminated from the differential diagnosis. The only plausible explanation left is that of a stretch injury to the first portion of the brachial artery with tearing of the muscular layers of the artery and resultant subintimal hemorrhage and subsequent aneurysmal formation.

The axillary vessels and the brachial plexus are encompassed in the axillary sheath which is a connective tissue layer reflection of the prevertebral layer of the deep cervical fascia.³ This sheath extends along the brachial artery but is decidedly thinner in the arm. Therefore, the axillary artery is held more firmly by this layer than the brachial vessels, making the latter more susceptible to a stretching type of trauma. The more flexible brachial artery is pulled away from the relatively fixed axillary artery with resultant injury at their junction. This mechanism of injury is postulated in the above reported case. To our knowledge there has been no previous report suggesting the stretch mechanism of injury in the brachial artery.

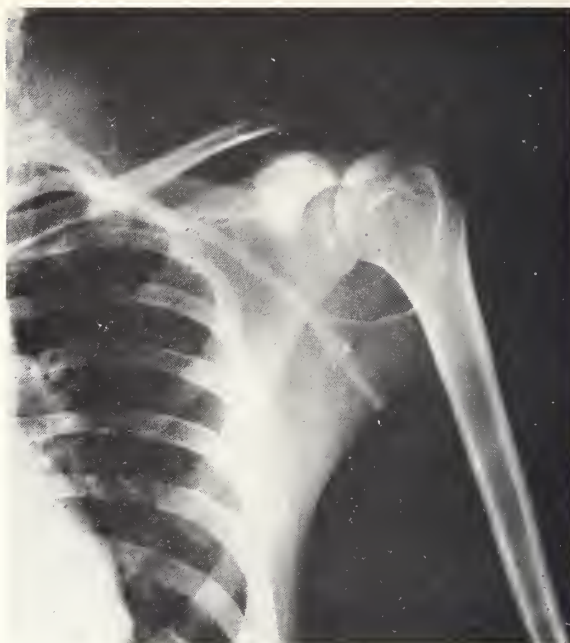


FIG. 2. Postoperative retrograde arteriogram showing normal potency of the vein graft.

Summary

A case history of sudden ischemia of the hand secondary to embolization from an aneurysm of the brachial artery is reviewed. A stretch type injury as the etiology of the aneurysm is proposed. A successful repair with resection of the aneurysm was accomplished by restoration of continuity with an autogenous greater saphenous vein graft.

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SUICIDES HIGHEST AMONG DOCTORS.—Dr. David E. De Sole, a psychiatrist at the VA Hospital in Albany, N. Y., has reported that suicides among physicians are three times more common than among the general population. The physician's greater tendency toward suicide stems from his heavy burden of treating the sick.

The medical profession, more than any other profession, carries with it an intensive commitment to caring for and healing his fellow man. While every profession and every individual shares in the role, the doctor has little escape from it. Neither his family, his professional associates, nor his friends provide sanctuary from the doctor's personal responsibility for individuals who need care. Even when he is sick there is no escape. —Veterans Administration Information Service, Washington, D. C., May 9, 1967.

Spatial Vectorcardiography

I. Essential Background Information

ROBERT T. MURNANE, M.D.*

VECTORCARDIOGRAPHY (VCG) is a method of determining the spatial location of cardiac electromotive forces (EMF). Since the heart is a three-dimensional structure located in a volume conductor (the body), the electric forces associated with the heartbeat have direction and magnitude in *space*.

Atrial and ventricular depolarization and repolarization pursue a loop pathway, "spatial" referring to the location of intervals along the loop pathway. The loop pathway and return to point of origin may be likened to the flight of a boomerang. Any interval will simultaneously be right or left, superior or inferior, anterior or posterior. For proficiency in any method of VCG, the normal spatial location of intervals of clinical usefulness must be memorized.

In clinical application the interpreter has access only to records presenting the cardiac EMF in wave (scalar) or loop (oscilloscopic) form. Each of these methods of presentation complements the other but either may be used to acquire information about the spatial location of meaningful clinical intervals.

The atrial and ventricular depolarization processes may be interrupted at intervals, the direction of which are determined predominantly by the electrical activity in specific areas of the myocardium. These portions of the muscle may be thought of not as areas of isolated activity but rather as having the most momentum at successive stages of the discharge process. There is simultaneous discharge at many locations throughout the myocardium. Much of this has a direction opposite to that of the interventricular septal discharge and therefore a cancellation effect on the latter. An exploring electrode cannot record activity in the myocardium directly beneath it to the exclusion of simultaneous electrical activity in other directions.

While this fascicle refers to the deflections of the recording instrument as waves, because of the traditional use of this term in scalar electrocardi-

ography, the word "loop" may be substituted for wave as a reminder that actually a loop pathway is inscribed. A scalar lead of the ECG merely taps the loop for its positive and negative deflections.

Atrial and Ventricular Intervals

The three-dimensional spatial location of the first half of the P wave is determined predominantly by right atrial discharge. This vector of .05 sec. dur-

TABLE 1. *Entities in which the scalar ECG is frequently helpful and occasionally decisive. Italicized categories are those in which the oscilloscopic VCG may be of adjunctive value.*

I.	Arrhythmias
	A. Atrial
	B. Ventricular
II.	AV Conduction Disturbances
	A. Block
	B. Accelerated Conduction (<i>W-P-W syndrome</i>)
III.	Ventricular Conduction Disturbances
	A. Bundle-branch block
	1. Complete
	2. Incomplete
IV.	Myocardial Hypertrophy and/or Dilatation
	A. Atrial
	B. Ventricular
V.	Ventricular Myocardial Ischemia
VI.	Left Ventricular Destructive Processes: Infarction
VII.	Pericarditis
VIII.	Electrolyte Disturbances
IX.	Drug Effects
X.	Low-Voltage States.

ation is directed left, inferior, and anterior. The second half of the P wave is also of .05 sec. duration; its spatial location is determined by left atrial discharge and it is directed left, inferior, and posterior.

There are four intervals during the ventricular activation process at which vector locations have clinical usefulness. The first eighth, the initial .01 sec. of the QRS wave, occurs as a result of the normal discharge from the left (posterior) side of the interventricular septum through to the right (anterior) side of the septum. This vector moves right, anterior, and superior or inferior. If the electrical axis is vertical, the force will be directed superiorly whereas if the axis is horizontal, the force will be inferiorly directed.

The second area of dominant momentum is that of the ventricular apico-anterior wall; this site of

The Heart Page is a periodic feature of *The Journal* containing brief, practical comments on subjects of immediate importance to practicing physicians. The comments are solicited by the Professional Education Committee of the Ohio State Heart Association.—Ed.

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activity determines the second eighth, the .01-.02 sec. vector, of the QRS wave. It is directed left, inferior, and anterior.

The third clinically useful vector interval of the ventricular activation process extends from the .02 sec. interruption to the .06 sec. mark and is dominated by the free wall of the left ventricle. This vector is directed left and posterior; if the heart has a vertical electrical axis, this force is directed inferiorly; if a horizontal axis, the force is directed superiorly.

The fourth vector interval, which extends from the .06 sec. mark to the .08 sec. termination of the QRS wave, represents activation of the posteromedial left ventricle, the basal portion of the septum, and the outflow tract of the right ventricle. It is directed posteriorly, slightly right or left, and slightly inferiorly or superiorly.

The T wave representing ventricular repolarization is directed left, inferior, and anterior.

It is to be reemphasized that these vector intervals and their three-dimensional *spatial* locations must be memorized, to recognize departures from the normal on the scalar or loop presentation of cardiac EME. With corollary clinical information, probabilities regarding etiology of the abnormalities can be proposed.

The accompanying Table 1 lists entities in which the oscillographic-loop VCG can be of adjunctive value to the clinical ECG.

(To Be Continued)

From the Department of Medicine, Mount Carmel Hospital, Columbus, Ohio.

The Project in Oscillographic Spatial Vectorcardiography has been supported by grants from The Central Ohio Heart Association.

VASCULAR DISEASE CANDIDATES. — Investigators at Pennsylvania Hospital, Philadelphia, believe they have found a simple test that may identify young persons who are predisposed to vascular disease later in life. If this proves out in further studies, it should then be possible to adopt preventive measures such as low-fat and low-sugar diet, avoidance of stressful occupations, regular vacations and treatment of high blood pressure if and when it appears. The test is based on biomicroscopic observations of more than 3,500 patients. Those with cerebral vascular disease displayed gross structural changes in the smallest blood vessels of the eye together with marked sludging of the blood. Of even greater significance is the fact that some apparently normal men and women in the 25-35 year age group display the beginning of similar changes in the eye, and the majority of such people have a family history of strokes, coronary disease, or diabetes.

The observed heavy sludging has also suggested a new theory on the development of vascular disease, i.e., that sludging may block the vasa vasorum of larger arteries and that this damage plays a part in initiating thrombosis within the large vessels.

That sludging can produce arterial thrombosis in experimental models has been demonstrated. It has not yet been shown that these experimental findings apply to the naturally-occurring disease but the work appears to reconcile many of the apparently conflicting reports of others in the field of atheroma and thrombosis. (Principal Investigator: Frank A. Elliott, M.D.) — *The John A. Hartford Foundation, Inc. Bulletin*, No. 3, June 1967.

Maternal Deaths Due To Choriocarcinoma*

By the OSMa COMMITTEE ON MATERNAL HEALTH

With Comment of Consulting Gynecologic Pathologist

MALIGNANT, invasive trophoblastic neoplasm, designated as choriocarcinoma, or chorionepithelioma, is not seen frequently in this hemisphere, as a primary cause of maternal death. Only *five* of the 779 maternal deaths in Ohio during a 10 year survey of maternal mortality (OSMJ, 63:323-332, Mar., 1967) were due to choriocarcinoma. Since this report (1955-1964) two more cases have been added to the official files. The Consultant, in his comment (below), discusses frequency, source, diagnosis, metastasis and therapy.

Herewith, the Committee presents *three* cases involving choriocarcinoma. The first patient died *seven* months postabortal (no mole), the second patient died *seven* months postabortal (mole), and the third patient died *35 days* postlaparotomy for a "tubal" choriocarcinoma.

Case No. 726

A 21 year old, white, Abortus II, died *seven* months postabortal. Her past history was noncontributory. The first pregnancy (a year before) terminated in a two-and-a-half month spontaneous abortion. There was no dilation and curettement (D and C). Most recent, the patient had a normal period in January followed by a five day period (February 10). On February 15 she bled profusely, was admitted to a hospital (in another State), given *three* units of blood and submitted to a D and C. The pathologist reported "syncytial endometritis and 0.9 cm. fetus." The chest x-ray was reported normal.

On March 17 she was readmitted with a positive pregnancy test and negative chest x-ray; pelvic examination was reported negative. A second D and C showed only "secretory endometrium."

Her next regular period was April 1 following which intermittent bleeding occurred. On April 16 the pregnancy test was *positive*. With intermittent vaginal bleeding, the patient was readmitted April 26, at which time a D and C showed "proliferative endometrium." Two days later the pregnancy test was *positive*, but the chest x-ray was *negative*.

Profuse bleeding recurred May 20. Pelvic examination now revealed a 6 cm. mass in the left adnexal region. The

patient received blood transfusion, and a pelvic laparotomy was performed. A 5 cm. ruptured corpus luteum cyst was bleeding! The ovary was repaired; further exploration revealed no additional visceral disease. Although the uterus appeared grossly normal, a total hysterectomy was performed. Pathology Report: "Chorioadenoma Destruens." Chest x-rays were reported negative. Later the microscopic slides, reviewed in Boston, were reported "choriocarcinoma within uterus." The patient's recovery was excellent during June.

Later the patient was seen in consultation in Washington, D. C., National Institutes of Health (NIH), where she was advised to submit to methotrexate therapy; she declined. On August 1 she had a sudden hemoptysis; chest x-rays were negative. Bronchoscopy revealed no positive findings. The 18th of August a repeat chest film now showed metastasis to the right lung. Returning to Washington, D.C., the patient was again advised to receive methotrexate therapy; she chose to return to an Ohio Medical Center, and was admitted to a local hospital on September 8. Physical examination revealed a dyspneic patient with pulmonary rales, engorged breasts and a fever. Her pelvis was negative.

Laboratory Studies: Anemia, with 500,640 platelets. Methotrexate therapy was started promptly but the patient developed dyspnea, epistaxis, bloody diarrhea, and the clinical course was progressively downhill. The patient died September 21.

Cause of Death (Autopsy): Choriocarcinoma, metastatic to lungs; pleural hemorrhage due to metastatic tumor; status post-hysterectomy.

Comment

The Committee, after thorough deliberation, voted this a nonpreventable maternal death. Several members questioned the element of delay caused by the patient's reluctance to accept methotrexate therapy. However, it was pointed out that this chemotherapy was not too well known (to the public) a decade or more ago.

Case No. 565

This patient was a 21 year old, colored, Para I, Abortus I, who died *seven* months postabortal (mole). Her past history was not remarkable; there was a previous term pregnancy terminating without complication in a vaginal delivery. In February (five months) the patient registered in a clinic, declaring her last menstrual period appeared September 9, followed by "spotting" in December and January. Although details of her initial physical examination are not recorded, the fetal heart tones were not heard. The serologic test for syphilis was negative. Vaginal spotting continued intermittently, between frequent visits to the

*A continuous state-wide Maternal Mortality Study is being conducted in Ohio by the Committee on Maternal Health of the Ohio State Medical Association, in cooperation with the Ohio Department of Health and representatives of the various County Medical Societies. Summaries of some of the cases studied by the Committee, based on anonymous data submitted, are published here from time to time, interspersed with statistical summaries.

clinic. In March, an x-ray of the pelvis revealed no fetal skeleton (the size of the uterus was not recorded).

On April 6 the patient passed "grape-like" tissue vaginally and was admitted to the hospital with chills and fever. Antibiotics were administered. With the cervix dilated 4 cm. a dilation and curettement was performed April 8. The pathologist reported: "Degenerating decidua and clots; fetal membranes; occasional islands of trophoblastic cells." She was discharged the following day, reappearing in the clinic in May with an enlarged uterus, and no menstrual period. Progesterone was administered intramuscularly as a test for pregnancy. Next, she was seen in the emergency room July 1, complaining of "chest pains." Chest x-rays revealed multiple areas of density (1 mm. to 2.5 cm. in diameter), with evidence of fluid in the right costophrenic angle! Admitted to the hospital, a "frog test" was positive for pregnancy. Two days later a dilation and curettement was performed; the pathologist reported "glandular and stromal endometrium." A "rat test" for pregnancy was positive.

On July 8 a total abdominal hysterectomy with bilateral salpingo-oophorectomy revealed no evidence of choriocarcinoma, only "luteal transformation of the theca interna of ovaries."

July 10 the patient suffered an intracranial vascular accident and became comatose, a lumbar puncture yielded grossly bloody spinal fluid. Six days later the patient experienced sudden, spontaneous recovery. An electroencephalogram showed diffuse encephalopathy. On July 27, 500 cc. of blood was removed from the right thorax, but no tumor cells were found in it. Three days later treatment was started on methotrexate, penicillin and streptomycin. The chorionic gonadotrophin titer was 6,000 international units.

The patient received two series of methotrexate five days each, plus testosterone 25 mg. daily to improve protein anabolism. Chest x-rays revealed some reduction in size of the pulmonary lesions by August 31, and chorionic gonadotrophins were less than 750 international units. Whole blood was administered to correct anemia. After a total of 425 mg. methotrexate had been given, it was discontinued September 9. The patient was discharged, and readmitted September 17 at which time she had gained 6 lbs. in weight. Additional methotrexate was administered, chorionic gonadotrophins were negative and she was discharged on October 4.

On readmission November 4, x-rays showed a decrease in the size of the pulmonary nodules, but the gonadotrophin titers were elevated. Another course of methotrexate was begun. The blood urea nitrogen was 12 mg.; leukocytes 5,150; hemoglobin 11.2 Gm.; platelets were 200,000.

Convulsions developed November 11 followed by coma. A lumbar puncture produced grossly bloody fluid. The patient died 18 hours later.

Cause of Death (Autopsy): Chorioepithelioma, metastasis to lungs, spleen, kidney and cerebrum; subarachnoid hemorrhage; cerebral edema; bronchopneumonia; status *post D* and *C* (two) and hysterectomy with bilateral salpingo-oophorectomy.

Comment

The Committee studied this case with more than usual interest. Several points of question arose during discussion: (1) What were signs elicited on physical and pelvic examination from her first clinic visit, February to March when x-ray was obtained? (2) Were gonadotrophin titers followed after the *D* and *C* was done? Until July? Members agreed on the rather futile clinical outlook, once the metastatic lesions were identified. Several remarked on the pathologic absence of the tumor in the uterus, tubes and ovaries following surgical removal, a fairly common occurrence. After prolonged discussion, the Committee voted this a nonpreventable maternal death.

This patient was a 34 year old, colored, Para I, Abortus I, Ectopic I, (choriocarcinoma) who died 35 days post-laparotomy. Although her past history in general was not remarkable, the obstetric history was important; four years previously the patient had a term fetus delivered normally without complications. However, three years previously, in June, a *D* and *C* was performed confirming the diagnosis "hydatidiform mole." Two months later (August) because of bleeding, a second *D* and *C* was done. The following March (seven months later) a third *D* and *C* was performed because of midcycle spotting, and a positive pregnancy test (February). The tissue obtained "grossly resembled molar tissue" (no pathologic confirmation).

The patient remained well and without medical care for a period of 32 months. On November 22 she was admitted to the hospital with sudden right lower abdominal pain and in shock. Pelvic examination revealed a somewhat enlarged uterus, exquisitely painful to motion. During a laparotomy the right uterine tube was enlarged, and ruptured containing a mass suggesting a pregnancy. Both the tube and ovary were removed, and were reported to show choriocarcinoma. Two consecutive chest x-rays were reported negative.

The patient's postoperative course was excellent and she was discharged in good condition December 6. She continued to have some right lower quadrant abdominal pain at home. Soon she developed nausea, dyspnea and was readmitted December 27. A chest x-ray revealed multiple pulmonary metastases. Three hours after admission she died.

Cause of Death (Autopsy): Choriocarcinoma of right fallopian tube, metastases to pelvic peritoneum and lungs; pulmonary edema; status *post* right salpingo-oophorectomy; focal necrosis of medulla of one adrenal.

Comment

With intrigue and keen interest, the Committee studied and discussed this case. Members noted the length of time (32 months) between the removal of the mole, and the uterine tube containing the choriocarcinoma. Possibilities of a dormant rest of trophoblastic cells remaining in the interim, were entertained. However, members noted that the patient was not closely followed during this period, with pregnancy tests, etc. Upon this premise, members felt that perhaps chemotherapy might have been commenced earlier, certainly after discovery of the choriocarcinoma, although this probably would have been too late. By a narrow margin, the Committee voted this a preventable maternal death.

Comment of Consultant

The following comment of a consultant, who is a Gynecologic Pathologist, was furnished at the request of the Committee.

"Rather than comment separately on each of the three maternal deaths due to choriocarcinoma, I would prefer making some general comments regarding this disease.

"In spite of the rarity of choriocarcinoma, occurring only once in approximately 40,000 deliveries, it must be considered in the differential diagnosis of abnormal bleeding following complications of pregnancy — either abortion or, more particularly, hydatid mole, and even following term pregnancy. While it is generally known that choriocarcinoma follows hydatid mole and abortion, it should be re-emphasized

that approximately 25 per cent of choriocarcinomas have followed term pregnancies.

"While the Committee has designated two of these deaths as nonpreventable, the importance of early diagnosis of choriocarcinoma can be emphasized by the fact that this disease, which a dozen years ago was considered almost universally fatal within six months (9 per cent survival), in the advent of chemotherapy, particularly methotrexate and/or actinomycin D, that we now have come to expect a survival rate of 70 per cent or better among these patients.

"Fortunately, this disease has a signal in the fact that the pregnancy tests are positive either in recurrences or with insufficient treatment. However, this can be a double-edged sword, as the usual available pregnancy tests can be quite misleading since there is a high number of false negative reports, particularly at the low-titer levels. Therefore, it is essential that an accurate test method be available for these studies. At the moment the mouse uterine weight bio-assay is the most acceptable method; it is hoped that a radio-immune assay will be available for general use in the future.

"In the past, the accepted treatment of invasive mole and choriocarcinoma had been hysterectomy and to many, the treatment of trophoblastic disease without a histopathologic diagnosis was unacceptable. However, since approximately 18 per cent of the uteri removed from choriocarcinoma show *no* residual disease, and since many pathologists will not accept a diagnosis of choriocarcinoma from curet-

tings alone, and since it is not possible to determine the potential malignancy of a hydatid mole from histologic studies, and since in a patient who has a mole and may have metastatic lesions, these lesions, particularly pulmonary, are not biopsied, it is our feeling that these patients should be treated promptly by chemotherapy.

"Following a molar pregnancy, when the pregnancy tests remain positive and rising after 60 days, it has been shown that these patients have a 50 per cent chance of developing trophoblastic disease, either choriocarcinoma, or invasive mole. We feel that patients who have a persistently high or rising titer 30 to 60 days after evacuation of a mole should be treated! If therapy is not needed — or in those patients who have completed therapy — physical examination, gonadotropic titers, and chest x-ray studies are performed each month *for one year*. Pregnancy is to be avoided for from one to two years! Since the minor complications of the contraceptive pills are all those that signify a possible recurrence of choriocarcinoma, such as irregularity, spotting, nausea and vomiting, we feel 'the pills' are contraindicated in these patients.

"In closing, I would just like to emphasize that in patients who have treatment begun within four months of their complication, who have a low initial titer (less than one million) it has been shown that they will have approximately 95 per cent remission rate. Therefore, establishment of a very early diagnosis and prompt institution of therapy cannot be overemphasized."

METASTATIC MALIGNANT TUMOR NODULES of the skin from primary breast and melanoma lesions, and malignant tumors of the oral cavity and the rectum were treated by cryotherapy. All patients had advanced disease. The local lesions regressed after cryotherapy, some with no evidence of recurrence after 18 months. Serum antibodies against normal and abnormal cellular components (DNA) were measured at intervals before and after cryotherapy. Dramatic rises in these antibody titers to tumor DNA were seen in some of the patients undergoing cryotherapy. Evidence suggests that these antibodies may have some effect in inhibiting growth of residual untreated tumors." —William G. Pace, M.D., The Ohio State University Hospitals, Columbus, Ohio 43210. —EXCERPT: *The John A. Hartford Foundation, Inc. Bulletin*, No. 3, June 1967.

A Clinicopathological Conference

From The Ohio State University Hospital, Columbus, Ohio

Edited Under the Auspices of the Ohio Society of Pathologists

PAUL N. JOLLY, M.D., *President*

PRESENTATION OF CASE

FIRST HOSPITALIZATION: Six years prior to the final (third) admission this 78-year-old white man entered University Hospital with complaints of weight loss of 46 lbs., swelling of the ankles, anorexia, and tarry stools. Physical examination disclosed blood pressure of 110/60, pulse rate 88 per minute, respirations normal, a thoracic kyphoscoliosis, slight ascites, a small ventral hernia, atrophic testicles, a mild hypospadias, and 3-4 plus edema of the feet and legs. The pertinent laboratory data at that time were a hemoglobin of 8.6 Gm., a serum calcium of 11 mg./100 ml.; urine having a specific gravity of 1.018 and 3-4 red blood cells per high-power field; no free hydrochloric acid on gastric analysis, and a Schilling's test diagnostic of pernicious anemia. Vitamin B₁₂ injections and digoxin were started and the patient responded well. After discharge, he was treated as an outpatient with vitamin B₁₂ injections and digoxin.

Second Hospitalization

Two months prior to his final admission the patient had the onset of pain with swelling and bluish discoloration of his right leg and thigh. He was admitted to the hospital with a diagnosis of thrombophlebitis. He had had nocturia of one to five times a night with some hesitancy. On physical examination the blood pressure was 140/85, pulse rate 84 per minute, and respirations normal. He had cervical venous distention, a slight increase in the anteroposterior diameter of his chest, and an edematous and tender right lower extremity.

The patient was placed on bed rest and was treated with heparin for thrombophlebitis. This responded without incidents. However, the results of routine laboratory tests were surprising. The hemoglobin was 14 Gm.; the differential white blood cell count was normal. The urinalysis showed 2-4 white blood cells. The blood urea nitrogen (BUN) was 31 mg./100 ml. The serum calcium was 6.2 mEq./liter, the serum phosphorus was 2.4 mg./100 ml., and the serum

Presented by

- Jack M. George, M.D., Columbus, and
 - Emmerich von Haam, M.D., Columbus.
- Edited by Dr. von Haam.

amylase value was normal. The electrocardiogram showed many premature ventricular contractions with ST and T wave changes. The chest x-ray films showed fibrosis of the lungs, and the gastroduodenal examination and an intravenous pyelogram were reported as normal. There were some degenerative changes in the bones of the spine, hands and fingers.

Various diagnostic procedures were performed to determine the etiology of the elevated serum calcium. The values obtained on serum electrophoresis were within normal limits. The alkaline phosphatase was 5.5 units. In a 24-hour urine specimen, 200 mg. of calcium per liter and 1 Gm. of phosphorus per liter were excreted. A cortisone suppression test did not significantly lower the calcium level of 13-14 mg./100 ml.

The patient began having frequent premature ventricular contractions and EDTA was administered. This decreased the calcium level slightly and decreased the frequency of the premature ventricular contractions. On quinidine, his ventricular irritability decreased. The patient was then discharged with directions to drink 3 liters of fluid per day and was given ammonium chloride, 2 Gm. four times daily.

Final Hospitalization

About one month later the patient was readmitted with nausea, vomiting, anorexia, and confusion. He had been feeling fairly well until three days prior to admission, when his level of consciousness progressively deteriorated and on the day of admission he was quite obtunded and somewhat dehydrated. The family reported that the patient had complained of abdominal pain about one week prior to admission and this preceded the anorexia and vomiting. He

would not eat or drink and his urinary output decreased. He had had his last bowel movement two days prior to admission.

The physical examination revealed a blood pressure of 130/75, pulse 60 and regular, respirations 17, and temperature 98 F. The patient was disoriented and appeared chronically ill. The skin was pale but had fair turgor. The breath sounds were decreased throughout both lung fields. The heart was not enlarged, and there were no gallops or murmur; there were frequent premature contractions. The abdomen was soft and without masses. Bowel sounds were decreased.

The following laboratory values were obtained: Hemoglobin 8.7 Gm.; white blood cell count 6,000 with 91 per cent neutrophils; slight hypochromia and anisocytosis noted on the blood smear; platelet count 60,000. The urine pH was 5.0; specific gravity 1.016; the urine contained 20 mg. of protein per 100 ml., 2-3 white blood cells and many red cells, and a few calcium oxalate crystals. The alkaline phosphatase was 3.3 units. The serum calcium was 15 mg. The serum electrolytes were otherwise normal. The BUN was 16 mg., uric acid 8 mg., creatinine 1.6 mg., blood sugar 102 mg., and phosphorus 3.2 mg. per 100 ml.

The electrocardiogram revealed premature ventricular contractions with run of bigeminy and non-specific ST-T wave changes. The initial chest film showed no change from the previous films. However, on the third hospital day there was elevation of the right diaphragm suggesting an infiltration in the posterior segments of the right lower lobe.

The patient's symptoms were thought to be due to a hypercalcemic crisis. He was begun initially on infusions of sodium EDTA in an attempt to lower his serum calcium. In the next 48 hours pneumonia developed in the right lower lobe and antibiotics were begun.

On the fourth hospital day a neck exploration was performed under general anesthesia and an enlarged parathyroid gland was removed. A tracheotomy was performed and the patient was maintained on a respirator for five days following surgery.

Postoperatively, the serum calcium remained elevated in the range of 6.5 to 7 mEq./liter (13-14 mg./100 ml.). The serum magnesium level was low (0.45 mEq./liter), and he was given injections of magnesium sulfate. In the immediate postoperative period he had several episodes of twitching, which responded well to the magnesium administration. The cardiac arrhythmias increased markedly, with frequent runs of auriculoventricular dissociation. On the eighth postoperative day he had a cardiac arrest from which he was resuscitated. His urinary output declined. Two days prior to death his calcium decreased to 10.4 mg. However, at this time he was edematous and had almost complete renal shutdown. He also had a further decrease in his bowel sounds

and his abdomen became distended. Another cardiac arrest ensued, from which he could not be resuscitated. He died on the 21st hospital day.

CLINICAL DISCUSSION

DR. GEORGE: This was a 78-year-old man whose chief complaint on his third admission to University Hospital was nausea, vomiting, and confusion. These are classic symptoms for hypercalcemia, but they are certainly not very specific. The history goes back to six years before this admission when he complained about a 45 lb. weight loss, swelling of the ankles, anorexia, and tarry stools. He had a slight amount of ascitic fluid, small atrophic testicles, mild hypospadias, and 3-4 plus edema of the feet and legs. He was found to have pernicious anemia and evidently responded well to vitamin B₁₂ therapy. The leg edema apparently was thought to be due to congestive failure, because he was treated with digoxin. I am interested in the small atrophic testicles. It is a common feeling that as males grow older the size of the testicles decreases, but this is not true. Statistically, the most common cause of hypogonadism in the adult is Klinefelter's syndrome, and it would certainly seem that the patient most likely had Klinefelter's syndrome in addition.

Hypercalcemia

It is of note that the serum calcium was 11 mg. per cent on his first admission, which is right on the borderline between a normal and elevated serum calcium. Certainly it would have been very helpful to have repeated the serum calcium several times, because of a certain variability in its level. But considering the fact that we have only one serum calcium, we have to decide whether this person at that time *did* have an abnormal serum calcium. I think that's the crucial point of the story here, because of this interval of six years. If he had hypercalcemia six years before he died, he must have had some sort of chronic process causing his hypercalcemia. When we go through the differential diagnosis later, I think this factor will become more important.

He did well in the interim and then entered the hospital two months before his final admission because of thrombophlebitis. He also had some congestive failure at that time by physical examination. His hemoglobin was normal, his BUN was mildly elevated at 31 mg. His serum calcium this time was clearly elevated with a low serum phosphorus. His alkaline phosphatase was normal. He had 200 mg. of calcium per liter of urine and 1 Gm. of phosphorus per liter of urine in a 24-hour specimen. I don't think this really helps us very much since we really want to know the 24-hour excretion of these minerals.

It makes a big difference whether the patient excreted 800 ml. or 3 liters of urine during that 24-hour period. In general, the determination of urinary phosphorus is not helpful because it mostly reflects

the dietary intake of phosphorus. It is, however, helpful to determine the amount of calcium in the urine because there is a limitation of calcium absorption by the gastrointestinal tract. In the normal individual no more than 200 mg. of calcium will be absorbed over a 24-hour period. Therefore a urinary calcium excretion of greater than 200 mg. per day is distinctly abnormal regardless of the amount of calcium the patient has taken in his diet. There are a number of causes for hypercalciuria and we will discuss this in the differential diagnosis.

During the second admission a cortisone suppression test was performed and I assume that adequate doses were given over a period of seven to ten days. I am not sure that it is always appreciated that a fall in serum calcium in response to cortisone often does not occur within two or three days, and to have a valid test you have to continue cortisone for at least seven days and in adequate doses. However, he did not respond to this test and his serum calcium remained high.

Hypercalcemic Crisis

So he was discharged from the hospital but came back one month later with nausea, vomiting, anorexia, and confusion. Certainly at this point he had symptoms of a hypercalcemic crisis, and we are given a clue as to how he got into this state when we are told that he had abdominal pain about one week prior to admission which was associated with anorexia and vomiting. Certainly in a patient with hypercalcemia, it is extremely important that they take in adequate amounts of water. Otherwise they become dehydrated, the serum calcium goes up, they develop somnolence, anorexia and vomiting, which lead to further decrease in their water intake, with further hypercalcemia, and this vicious cycle can certainly result in death if not interrupted.

On admission to the hospital there was evidently nothing striking about the physical examination other than what had been previously noted. We note that his hemoglobin was low whereas it had been normal just a month before. Certainly this rapid fall in his hemoglobin would suggest blood loss as the most likely factor. Since he had had abdominal pain and pernicious anemia, a malignant gastric ulcer would seem a very good possibility and I think perhaps we will see some evidence of this in his x-rays. Something had happened in his abdomen which caused him to stop drinking water and he was in real trouble from his hypercalcemia. He now also had hyperuricemia, which has been described in roughly a quarter of the cases of hyperparathyroidism. His serum creatinine and phosphorous were also slightly elevated, probably just reflecting his state of dehydration.

He was initially treated for this hypercalcemic crisis with sodium EDTA and then was operated upon as a semiemergency procedure. One enlarged parathyroid

gland was removed. Following surgery his serum calcium did not fall and his serum magnesium was low. There are a number of causes for hypomagnesemia, of which hyperparathyroidism concerns us most. It has been said that the serum magnesium is low in these patients, particularly after a parathyroid adenoma has been removed. I think the cause of this is quite obscure. He continued to have severe trouble with renal shutdown, developed cardiac arrhythmias, and died. Perhaps this would be the best point to see any x-rays that are available.

Radiologist's Discussion

DR. CAMPBELL: The first series of films dates from 1958, and the esophagram shows no masses impinging upon the esophagus such as we can see in enlarged parathyroid glands or adenoma. The skull also did not show any of the salt-and-pepper type demineralization that we sometimes see in hyperparathyroidism. The kidneys were polycystic and the infundibula were displaced. A bone study in 1965 again shows no evidence of any osteoclastomas. His IVP in 1965 shows a decreased renal function naturally expected in progression of polycystic kidneys. No general demineralization of the bones was observed.

DR. GEORGE: I would like to make a comment here about the bone disease in hyperparathyroidism. It has the long name of osteitis fibrosa cystica generalisata, more commonly known perhaps as just fibrous osteitis. It does not occur in the presence of a normal alkaline phosphatase. So when we are told that this patient had a normal alkaline phosphatase we can pretty much be sure that we are not going to find anything abnormal on the x-rays of his bones. I think that is something worth keeping in mind.

Causes of Hypercalcemia — Excluded

Perhaps we should next discuss the causes of hypercalcemia. Just to mention one — sarcoidosis. His chest x-ray did not suggest pulmonary sarcoid, which is strongly against this diagnosis. Skin tests were not done. Sarcoid almost always responds to cortisone in terms of serum calcium, and he did not. So I think the diagnosis of sarcoid is very unlikely as the cause of hypercalcemia here.

Another cause of hypercalcemia is the milk alkali syndrome. He had renal insufficiency, which is a *sine qua non*, I think, for that syndrome, and he did have hypercalcemia. Again we are back to the point of whether he really had hypercalcemia six years before his death. The fact that his serum phosphorus was initially low speaks against milk alkali syndrome. I think the reason the serum phosphorus is usually elevated is the renal insufficiency. One point to remember about the milk alkali syndrome is that even after you stop the milk and the alkali it may be months before the serum calcium returns to normal. So you want to be very careful about operating on

a person's neck who has been treated for this sort of situation. I gather he did not have any symptoms or take any medications like this. So there is really nothing to support this diagnosis and I think we will dismiss that too.

Vitamin D intoxication is another cause of hypercalcemia. Evidently there was no history of excessive vitamin D ingestion in this patient. Again, vitamin D intoxication causing hypercalcemia will almost always respond to cortisone, which he did not. So I think we can disregard that. Immobilization hypercalcemia occurs in essentially only two instances: in children or teen-agers who are confined to bed with a cast, and in adults who are confined to bed with Paget's disease of the bone or metastatic bone tumors. Again we don't seem to have that here.

Thyrotoxicosis is another cause of hypercalcemia. We are not told that he had any studies of his thyroid function. Clinically, evidently, this diagnosis was not suggested although certainly we are aware that in the older patient this can be a very difficult diagnosis to make. Patients can have very severe bone disease and definite hypercalcemia on this basis. Again, some of these patients who have been treated with cortisone have responded. Certainly the treatment for this is the treatment of the thyrotoxicosis and this should invariably result in decrease of the serum calcium. The steroid withdrawal syndrome with hypercalcemia occurs in patients with Cushing syndrome immediately after removal of an adrenal adenoma or adrenalectomy, or in a patient with Addison's disease where steroid medication is suddenly stopped. Obviously we are not dealing with that here.

I hadn't been aware of the possibility of polycystic kidneys, but I was going to mention secondary hyperparathyroidism anyway. I think we can exclude secondary hyperparathyroidism in this case because the patient had an elevated serum calcium and a low phosphorus. As far as we know from the physiology of the parathyroid hormone, the low serum calcium level may be raised somewhat by hyperplasia of the parathyroid glands in renal disease but it should never be raised to frankly hypercalcemic levels. I think the fact that this patient had a low serum phosphorus, did not have fibrous osteitis, and that the BUN was only minimally elevated on one occasion exclude this possibility.

Causes of Hypercalcemia — More Likely

I have saved until last the causes of hypercalcemia that are the most difficult to exclude. We could sort of lump into a group the hypercalcemias associated with malignancy. Certainly it has long been noted that metastatic bone disease can cause hypercalcemia, but we have no evidence on the basis of bone x-rays or other symptoms that this patient had a malignancy. Here the calcium determined six years prior to the patient's death is quite important because if he really

had his disease causing hypercalcemia six years before his death it would be extremely unlikely that this was an asymptomatic malignancy which persisted until the time of death and even at that time gave no symptoms.

The other, perhaps more interesting, group of these patients are those who have a malignancy without any obvious bone metastases but who have hyperparathyroidism. This appears to be due to a parathyroid-hormone-like substance secreted by the tumor. This has been reported for tumors from almost all organs by now except the breast. Perhaps it is absent there because breast cancer so often metastasizes to bone that any hypercalcemia seen in this situation is assumed to be due to the bone metastasis. Cancer is becoming recognized as a more common cause of hypercalcemia and is really the most difficult one to exclude. Here history and physical examination are very important. Certainly an elevated serum calcium in a person who otherwise appears to be completely well speaks against a malignancy. If on the other hand the patient had weight loss, anemia, and an elevated alkaline phosphatase, without diffuse bone disease, a very careful search must be done before the patient is subjected to neck surgery. It is my understanding that in these patients the parathyroid glands are not enlarged. This is what you would expect if the tumor itself is producing a parathyroid-like hormone. So the fact that this patient had an enlarged parathyroid gland on exploration is against such a diagnosis.

So we finally come to the diagnosis of hyperparathyroidism, which is certainly consistent with a six-year history, a relatively asymptomatic but steadily worsening course, and the occurrence of a hypercalcemic crisis when dehydration intervened because of some problem in the abdomen. It is interesting that one enlarged parathyroid gland was found at surgery and that his hypercalcemia was not cured by the removal of this gland.

In the past it has been thought that hyperparathyroidism was synonymous with parathyroid adenoma, but this is not true. There are other causes of hyperparathyroidism. Carcinoma of the parathyroid glands is one, but this is extremely rare. There are occasionally multiple adenomas, but more common is idiopathic hyperplasia of the parathyroid glands, which are first described by Cope and Castleman in about 1956, I believe, and which now accounts for 25 per cent of all cases of primary hyperparathyroidism. This makes any surgery for this condition even more difficult.

If an enlarged parathyroid gland is found at surgery, it is not enough to remove that gland. You have to also prove that the other parathyroid glands are normal, and this surely can only be shown by biopsy unless an extremely experienced surgeon can identify the other parathyroid glands visually. This chief-cell hyperplasia is histologically indistinguish-

able from the secondary hyperplasia occurring in response to renal disease. It usually but not necessarily involves all four glands. The glands can be of varying sizes. So the fact that one enlarged parathyroid gland was found, and the fact that the patient continued to have hypercalcemia after surgery, suggest that he had other abnormal parathyroid tissue in the neck, and this would suggest a diagnosis of multiple adenomatosis, or primary chief-cell hyperplasia, which I think this patient had.

You can see how much hinges on the initial serum calcium that was obtained six years previously and really how important it is to try to follow up on a lab test which may initially be obtained by chance. Sometimes we are concerned, when we see a young person with an elevated serum calcium, whether we should subject this person to surgery, and what the ultimate prognosis is for a patient with a parathyroid adenoma who appears to be in good health at the time he is first seen. There isn't any answer to this because there haven't been any patients followed with known hypercalcemia, at least any series of note, but certainly it is a potentially lethal disease.

So in summary, I think the patient had hypercalcemia due to hyperparathyroidism on the basis of primary chief-cell hyperplasia, and I will expect that we will find it in the enlarged parathyroid gland that was removed at surgery and in other enlarged ones that I assume were found at autopsy. He also had congestive failure of obscure etiology, statistically at this age most likely arteriosclerotic heart disease. Evidently, from the x-ray, he had polycystic kidney disease and he had pernicious anemia. Finally, he had hypogonadism, most likely Klinefelter's syndrome. At the end something catastrophic happened in his abdomen and I will venture a guess that this was a gastric carcinoma developing in a patient with pernicious anemia.

General Clinical Discussion

DR. GREENBERGER: *Have you any thought why the patient might have thrombocytopenia in addition to his anemia?*

DR. GEORGE: No, I don't believe I do.

DR. RUPPERT: *Dr. George, have you ever observed malignant tumors to stimulate the parathyroid glands?*

DR. GEORGE: Occasional reports of this exist in the literature, without offering any reason.

MEDICAL STUDENT: *Is there any increased incidence of peptic ulcer in hyperparathyroidism?*

DR. GEORGE: It certainly has been reported and it represents part of the multiple endocrine adenoma syndrome described by Zollinger and Ellison.

DR. GREENBERGER: This is still a very confused area and depends upon the effect of serum calcium on the gastric secretion. A survey of all studies

suggests that about 10 per cent of the cases of hyperparathyroidism have peptic ulcer, which is higher than that found in the population. It also must be remembered that a fair number of the patients with primary hyperparathyroidism develop pancreatitis.

DR. VON HAAM: *Why?*

DR. GREENBERGER: A recent investigation suggests that with an increase in serum calcium a change in the enzymatic activity of the pancreas occurs with increased conversion of the zymogen precursors to the active enzymes. This then may lead, purely hypothetically of course, to autodigestion and necrosis of the pancreas.

CLINICAL DIAGNOSIS

1. Primary hyperparathyroidism due to idiopathic chief-cell hyperplasia of the parathyroid glands.
2. Arteriosclerotic heart disease.
3. Polycystic kidneys.
4. Pernicious anemia.
5. Klinefelter's syndrome.

PATHOLOGIC DIAGNOSIS

1. Primary hyperparathyroidism due to idiopathic chief-cell hyperplasia.
2. Acute necrotizing pancreatitis.
3. Arteriosclerotic heart disease.
4. Nephrocalcinosis with retention cysts, bilateral.
5. Pernicious anemia.

DISCUSSION OF PATHOLOGY

DR. VON HAAM: One point in the clinical diagnosis that we cannot clear up was whether indeed the patient had Klinefelter's syndrome. The autopsy surgeon described the testicles as "normal."

On opening the abdomen we found scattered areas of recent mesenteric fat necrosis and approximately 400 ml. of clear fluid. The fat necrosis obviously came from the pancreas, which was swollen and studded with areas of fat necrosis. Careful dissection revealed no evidence of bile duct disease and there were no hemorrhages. The heart was not enlarged but showed large myocardial scars. Both lungs showed basal atelectasis probably due to elevation of the diaphragm. The spleen was small. Both kidneys were enlarged and showed several solitary retention cysts. There was a recent infarct of the prostate. The brain was definitely atrophic. The bones did not show any gross evidence of demineralization or trabecular atrophy. The bone marrow grossly appeared very active. Two parathyroid glands were identified. One appeared small while the other was definitely enlarged.

Microscopic section of the heart confirmed the severe myocardial fibrosis which was the background for his

congestive heart failure. Microscopic section of the pancreas showed multicentric nonsuppurative, non-hemorrhagic necrosis of the glandular tissue surrounded by recent fat necrosis. The islands of Langerhans appeared normal. Microscopic section through the kidneys showed many calcified casts in the tubules while the glomeruli did not appear affected. The small and medium-sized arteries of the brain showed calcification of the muscular layer.

Section through the parathyroid glands revealed one normal gland consisting mostly of chief cells with dark cytoplasm. Section of the enlarged gland showed marked enlargement of the individual cells, forming acini with colloid-like content. There was marked irregularity of the cell size and of the size of the nuclei. The tissue appeared much more vas-

cular than that of the smaller gland. This change extended throughout the entire gland and was not restricted to an encapsulated nodular area. It resembled closely the microscopic picture present in the gland removed during surgery.

Section of the bone marrow showed some degree of atrophy of the bone spicules with a marked increase of megaloblasts in the marrow.

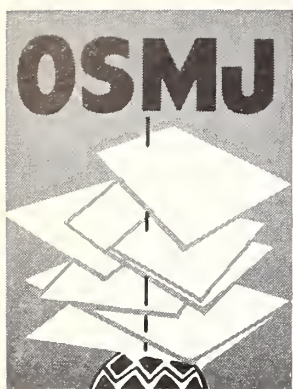
In conclusion then, we believe that the patient suffered from idiopathic chief-cell hyperplasia of the parathyroids with secondary nephrocalcinosis. The abdominal catastrophe that our clinical discussant referred to and which brought on the picture of hypercalcemic crisis was undoubtedly the multicentric fat necrosis of the pancreas, which was not recognized clinically.

ADVANCES IN BURN THERAPY.—Improved management of major thermal burns, developed by Emory University's Department of Surgery and practiced at its three affiliated hospitals in Atlanta, has brought about a dramatic reduction in mortality rates. Among children, mortality has been well below 2 per cent for the past two years compared with 18 per cent in 1961. Among all patients with third degree burns on 60 per cent or less of the body surface, mortality over the past three years has been just 0.6 per cent while among those with 60 to 85 per cent burned surface it is now 30 per cent as against 100 per cent a few years ago.

Progress in burn therapy is attributed to an intensive, three-year laboratory and clinical research program which includes:

- Early detection of *Pseudomonas* toxemia (green urine syndrome) by means of ultraviolet fluorescence of urine so that treatment can be instituted before salvage is impossible.
- Clinical application of a new antibiotic, Gentamicin sulfate which, following laboratory tests, proved to be lifesaving in a majority of burn wound infections that threatened death.
- Refinement of the meshed skin graft which provides up to 300 per cent expansion of the patient's own skin and reduces both mortality and the number of hospital days required.
- Use of a tissue adhesive, methyl-2-cyanoacrylate, for immobilizing skin grafts, which gives equal or better results than suture methods and substantially cuts down on operating time.
- Discovery that hypertension noted in patients with extensive third degree burns has its origin in an excessively-prolonged release of epinephrine and norepinephrine and that reserpine provides effective control. Once a major cause of burn deaths in the pediatric age group, hypertension is no longer a significant problem.

In addition, at Grady Memorial Hospital a burn room was set up in the operating suite which improved efficiency and cut down on cross-infections; and the position of burn nursing supervisor was instituted that has proven invaluable in spanning the gap between surgical and regular nursing services. (Principal Investigators: J. D. Martin, Jr., M. D., and H. Harlan Stone, M. D.) — *The John A. Hartford Foundation, Inc. Bulletin*, No. 3, June 1967.



NEWS AND *Organization Section*

Proceedings of The Council...

Matters Considered and Actions Taken at Meeting
Held in Columbus Headquarters Office on July 26

A MEETING of The Council of the Ohio State Medical Association was held in the Headquarters Office, Columbus, Wednesday, July 26, 1967. All members of The Council were present except Dr. Lawrence C. Meredith, Elyria, Immediate Past President. Others attending the meeting were: Mr. Wayne E. Stichter, Toledo, OSMA Legal Counsel; Mr. David B. Weihaupt, Chicago, AMA Field Representative; Dr. Robert E. Tschantz, Canton, Chairman of the OMI Liaison Committee; Mr. Charles H. Coghlan, Columbus, Executive Vice President, Ohio Medical Indemnity, Inc.; Dr. Edmond K. Yantes, Wilmington, President, Ohio Medical Indemnity, Inc.; Mr. Charles S. Nelson, Columbus; Mr. James S. Imboden, Columbus; Mr. Hugh F. Hughes, Columbus, Nationwide Mutual Insurance Company Medicare Manager for Ohio; Dr. Paul Metzger, Columbus, Vice-President, Nationwide Mutual Insurance Company; Messrs. Page, Gillen, Campbell, and Moore of the OSMA Headquarters Office.

Minutes Approved

The minutes of the meeting of The Council held May 19, 1967 were approved by official action.

Membership Statistics

Mr. Page presented membership statistics as follows: OSMA membership as of July 24, 1967, was 9,954, compared to a total membership of 9,921 on July 31, 1966. Of the 9,954 members, 8,731 were affiliated with the AMA.

Reports by Councilors

The Councilors reported on activities in their districts.

The Council instructed the Director of Public Relations to prepare an article for *The Ohio State Medical Journal* with regard to the history of the medical profession's attitude on the subject of the supply of physicians in the United States.

Resolutions Referred to Council

The Council acted as follows on resolutions referred to it by the House of Delegates at the 1967 Annual Meeting:

Resolution No. 6, regarding the collection of OSMA dues, was referred to the Committee on Auditing and Appropriations.

Resolution No. 10, regarding areawide health care planning, was referred to the Committee on Government Medical Care Programs for continued attention and with instructions to inform the membership.

Resolution No. 13, regarding physicians on hospital governing boards, which was introduced by the Ohio delegates at the June AMA meeting where a substitute resolution was adopted, was referred to the Committee on Hospital Relations.

Resolution No. 17, regarding the reapportionment of delegates to the OSMA, was referred to a committee of The Council headed by Dr. Ivins.

Resolution No. 7, regarding group malpractice insurance, was referred to the Committee on Insurance.

Resolution No. 8, regarding mental health centers, was referred to the Committee on Government Medical Care Programs.

Resolution No. 9, regarding additional medical schools in Ohio, is being implemented by The Council with testimony being offered by Dr. Light before the Ohio Senate Health, Education, and Welfare Committee July 26, 1967. Representatives of the Summit County Medical Society previously testified before the same committee.

1968 Annual Meeting

Mr. Campbell, secretary of the Committee on Scientific Work, reported on plans for the 1968 Annual Meeting. The dates, in Cincinnati, of May 13 through 17 were adopted by official action.

A report on the July 16th meeting of the Committee on Scientific Work on Annual Meeting subjects, speakers, and arrangements was approved with a number of minor modifications.

Amendments to County Society Constitutions and Bylaws

Butler County — A proposed change in the constitution, which would add the past three presidents to the council of the society, whereas previously only the past president served, was approved. A change in the bylaws to provide for two-year terms for delegates and alternate delegates to the Ohio State Medical Association was approved, subject to a suggestion of The Council that staggered terms be arranged for the delegates and alternates.

Franklin County (Academy of Medicine of Columbus and Franklin County) — Proposed amendments to the Amended Code of Regulations, which would make American Medical Association membership permissive (instead of mandatory) for members of the Academy, were approved.

Harrison County — An amendment to the bylaws, which would require a secret written ballot in elections to membership in the society, was approved.

Mahoning County — An amendment to the constitution to reduce the requirement for a quorum at a meeting of the society from 20 per cent to 10 per cent, was approved.

Committee Reports

Hospital Relations

Minutes of the meeting of the Committee on Hospital Relations held April 30, 1967, were presented by Mr. Gillen. Approval of the minutes included approval of the cosponsorship with the Ohio Hospital Association and the Ohio Association of Osteopathic Physicians and Surgeons of a second conference for chiefs of staff of Ohio hospitals.

Also approved as a part of the minutes was the following statement on hospital licensure:

"Approved the principle of hospital licensure as it relates to physical facilities, safety, and sanitation. Should a proposed legislation encompass patient care, it is recommended that the following language be included in such a bill: 'Each hospital shall have an organized medical staff responsible, to the Board of Trustees, for standards for the provision of professional medical care.'"

Environmental and Public Health

Minutes of meetings held April 12 and June 28, 1967 were presented by Mr. Gillen. An amendment to the April 12 minutes to provide that the chairman of the Public Affairs Committee of the Ohio Health Commissioners' Association be considered for membership on the Committee on Environmental and Public Health, was approved.

Also, with the acceptance of the report as a whole was a recommendation that the OSMA become active in the area of air pollution and that the Association ask for representation on an air pollution control board when such is established.

The statement of policy of the Ohio State Medical Association on mass immunization was amended by the committee, and The Council adopted the amended reaffirmation as follows:

"That the Ohio State Medical Association opposes mass immunization procedures except in epidemics or emergencies, or for indigent and institutional programs, and approves of these procedures in the private doctor's office or in facilities directly under his control." (New material is underlined.)

The Council also endorsed the committee's suggestion that when mass inoculation programs are instituted in accordance with the above exceptions they shall be under the joint sponsorship of the County Medical Society and the Health Department.

The April 12 and June 28, 1967 minutes were approved as presented.

School Bus Driver Examinations

The minutes of the meeting of the Joint Committee on School Bus Driver Examinations held April 19, 1967, were accepted for information as presented by Mr. Gillen.

Scholarship Subcommittee of the Committee on Rural Health

Minutes of the meeting of the Rural Health Scholarship Subcommittee held July 19, 1967 were accepted for information as presented by Mr. Gillen.

Government Medical Care Programs

Minutes of the meeting of the Committee on Government Medical Care Programs held April 26, 1967, were approved.

Subcommittee on 1967 Postgraduate Meetings, Committee on Mental Health

Minutes of the meeting of the Subcommittee on 1967 Postgraduate Meetings of the Committee on Mental Health held June 13, 1967 were presented by Mr. Gillen. The Council approved the minutes in principle. However, the approval of a number of regional meetings proposed by the committee was withheld, subject to the determination of the officers of the Association, due to problems of funding and the shortage of staff time available during the period contemplated.

Medicine and Religion

Minutes of a meeting of the Committee on Medicine and Religion held June 28, 1967, were presented by Mr. Campbell and were accepted by The Council.

Health Resource Task Group

The minutes of the meeting of the Health Resource Task Group were presented by Mr. Campbell and were accepted for information.

Subcommittee of Ohio Hospitalization Benefits Committee

Meetings of the Crawford Subcommittee of the Ohio Hospitalization Benefits Committee held May 10 and July 12, 1967, to study direct billing and Blue Cross contracts providing for professional and medical services, were presented by Mr. Campbell and were accepted for information.

Workmen's Compensation

The Council reviewed the file with regard to a Workmen's Compensation case submitted for review by the Bureau of Workmen's Compensation through the OSMA to the Stark County Medical Society. The case had to do with the charges for an excision of a cystic tumor on the right perineal nerve. Dr. Westbrook was requested to obtain more information on the case for further review at the next meeting of The Council. Mr. Campbell was asked to advise the Bureau of Workmen's Compensation that the case is in process of further revision.

With regard to the review of a case which had been referred by the Bureau of Workmen's Compensation through the OSMA to the Academy of Medicine of Columbus and Franklin County, The Council reviewed the file in the case of a charge for anesthesia for an emergency surgical procedure. The Council upheld the decision of the Columbus Academy of Medicine that the charge in this case was a reasonable charge.

Direct Payment and Direct Billing

There came before The Council a question with regard to the acceptance of payment made by the Bureau of Workmen's Compensation to physicians under the Workmen's Compensation program. The Council expressed the opinion that the responsible

party can be other than the patient under certain circumstances, provided the patient is billed by the physician.

A letter from Dr. Edmund F. Ley, Tiffin, with regard to House Bill 500, legislation to permit private insurance companies to write workmen's compensation insurance in Ohio, was accepted for information.

Ohio Medical Indemnity, Inc.

A report of the OMI Liaison Committee was presented by Dr. Tschantz. Dr. Yantes and Mr. Coghlan addressed The Council with regard to an insurance program of the steel companies for their employees which shall become effective August 1, 1967. After considerable discussion the following action was taken:

"The Council approves the action of Ohio Medical Indemnity, Inc., in writing an industrial contract without an income ceiling and without mandatory use of a county medical society mediation committee, or its equivalent, and based on the individual physician's usual, customary, and reasonable fee."

Referred to Committee on Insurance

The following communications were referred to the OSMA Committee on Insurance:

A communication from the Cleveland Radiological Society concerning a plan developed by Blue Cross of Northeast Ohio for the payment of radiologists.

A letter from a member concerning a mailing being used by Daniels-Head & Associates, Portsmouth, in promoting the sale of insurance.

A report of the OSMA Group Life Plan from September 1, 1966 to March 1, 1967.

A letter from the Lorain County Medical Society regarding statements by certain insurance companies.

Ohio State Society of Medical Assistants

The Council authorized *The Ohio State Medical Journal* to carry promotion material on the membership program of the OSSMA in three issues of *The Journal* without charge.

The Council accepted for information communications from the president of the Ohio State Society of Medical Assistants and from the chairman of that society's hospitality committee, expressing appreciation for the financial assistance provided by the Ohio State Medical Association in honoring the national president from Ohio during the national convention of the organization in Los Angeles in October, 1967.

Medicare in Ohio

Mr. Hugh F. Hughes, Medicare Manager in Ohio for the Nationwide Insurance Company, appeared before The Council at this time to present a status report

on Medicare in Ohio. His report was accepted for information.

Tuberculosis Control Program

The Council approved a program on the use of chemoprophylaxis against tuberculosis, proposed by Dr. Seymour Katz, Tuberculosis Control Officer, Ohio Department of Health, in a communication to The Council dated May 9, 1967. The project would involve the sending of reprints of the Ohio and American Thoracic Societies' recommendations on the use of chemoprophylaxis against tuberculosis to all the physicians in Ohio as a joint recommendation of OSMA and the Ohio Department of Health.

Smoking and Health

A request from the Cincinnati and Hamilton County Interagency Council on Smoking and Health, that the OSMA conduct a survey on behalf of this agency involving the entire membership of the Association, was studied by The Council. Due to the fact that this involved a request from a local group to a state organization for a survey of its membership, which would set a precedent and would tend to involve more requests than the Association could meet, The Council expressed the opinion that the request cannot be granted.

Fall District Conferences

The Executive Secretary surveyed the opinions of the individual members of The Council in regard to places and dates for the Fall District Conferences of the OSMA with the County Medical Societies.

The Council then adjourned until the next meeting scheduled for September 15, 16, 17, 1967.

Attest: HART F. PAGE,
Executive Secretary

Cleveland Clinic Foundation Announces PG Courses

The Cleveland Clinic Educational Foundation has announced a number of postgraduate courses to be offered during the 1967-1968 season. Details on the various courses may be obtained by writing to Walter J. Zeiter, M.D., Director of Education, The Cleveland Clinic Educational Foundation, 2020 East 93rd Street, Cleveland 44106.

Following are the courses scheduled for 1967:

Medical Technology — September 15.

Update 1967 — Selected Topics in Nursing — October 18.

Problems in Pelvic Surgery, November 8-9.

Pain: Neurological and Neurosurgical Aspects — November 15-16.

Postgraduate Course in Ophthalmology — December 6-7.

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OSMA Scholarships Awarded . . .

Eight Medical Students Now Receiving Scholarships as Two Outstanding Freshmen Are Named by Committee

MR. Alan Theodore Tong and Mr. William H. Kose, two very outstanding young medical students, were elected to receive the scholarships awarded annually by the Ohio State Medical Association.

Dr. Robert E. Howard, President of the Association, announced the winners in mid-July following the final selection by the Scholarship Subcommittee of the Committee on Rural Health.

The two recipients of the awards were selected in competition with thirteen other extremely well qualified, knowledgeable young medical students. Dr. Howard, in announcing the winners, expressed regret that the OSMA could not provide a scholarship for each of the applicants inasmuch as he felt each one was deserving of assistance.

Mr. Tong, son of Mr. and Mrs. Clifford Tong, is from McComb, Ohio, near Findlay. He completed his premedical studies at the Bowling Green State University and has been accepted in the 1967 Freshman Class of the Ohio State University College of Medicine.

Mr. Tong, who is married, expressed in his application a desire to become a family physician in a small community. "Having lived in a small community, I can appreciate and understand the need for this particular type of practice," he wrote. Besides fulfilling the need, I believe this kind of practice offers the physician the greatest personal satisfaction. Also, the physician can work with the entire family and the medical problems of each general age group. A family practice affords the doctor the opportunity to know the patient's background and home life."

Mr. Kose, son of Mr. and Mrs. Paul H. Kose of Pickerington, Ohio, completed his premedical work at the Ohio State University where he maintained a 3.95 average. Mr. Kose, elected to Phi Beta Kappa this year, will start his medical studies at the Ohio State University College of Medicine where he has been accepted in the Freshman Class of 1967.

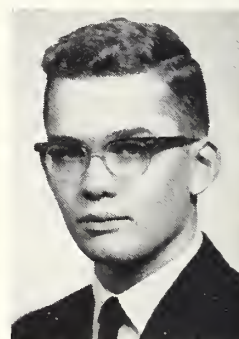
Mr. Kose, who has been active in Young Republican Clubs, also expressed a hope to the Scholar-

ship Subcommittee that he would become a family doctor practicing in a rural community.

The members of the Scholarship Subcommittee were: Luther W. High, M.D., chairman, Millersburg; Walter A. Campbell, M.D., Coshocton; E. D. Mattmiller, M.D., Athens; and Leonard



Alan T. Tong



William H. Kose

S. Pritchard, M.D., Columbiana. The subcommittee bases its selection on the following criteria: Character, integrity, intelligence, mature personality, interest in community life, leadership, and scholastic ability.

The Ohio State Medical Association scholarships were initiated in 1949. Since that time, 15 recipients of the awards have graduated from medical schools. In September of this year there will be eight winners who will be starting or continuing their medical studies. There has been no winner who has failed to complete his medical studies.

Each winner of a scholarship receives \$2,000 (\$500 a year) to help meet some of the expenses of medical school.

The 25.8 million veterans now in civil life range in age from teenagers to over 90. Their average age is 44 years, according to the Veterans Administration. The 14.8 million veterans of World War II now average 48 years of age, and the average age of the 5.8 million veterans of the Korean Conflict is 38.

Political Action in Ohio . . .

Workshop on Political Action for Physicians and Wives To Be Sponsored by OMPAC in Columbus, Sunday, October 8

A WORKSHOP ON POLITICAL ACTION for physicians and their wives will be held on Sunday, October 8, at the Sheraton-Columbus Hotel, Columbus, under the sponsorship of the Ohio Medical Political Action Committee.

Invitations for the conference on practical political action will be mailed early in September. Those being invited will include the following: Officers, Councilors, AMA delegates and alternates, and members of the Legislative Committee of the Ohio State Medical Association; presidents, presidents-elect or vice-presidents, secretaries, executive secretaries, and legislative chairmen of Ohio's County Medical Societies; officers, directors, and members of the legislative committee of the Woman's Auxiliary to the Ohio State Medical Association; presidents, presidents-elect or vice presidents, secretaries, and members of the legislative committees of the County Auxiliaries.

The workshop will start at 10:00 A. M. with registration opening at 9:30 A. M. There will be a complimentary luncheon at 12:00 NOON. Out-of-state guest speakers of distinction have been secured for the program which is as follows:

"OSMA Plus OMPAC Equals Political Action" — Charles S. Nelson, Columbus, former Executive Secretary of the Ohio State Medical Association and a consultant to OMPAC.

"Working With the Candidate's Organization" — Charles D. Ross, Dayton, who successfully managed the campaign of Congressman Charles W. Whalen, Jr., at the 1966 General Election.

"Don't Underestimate the Political Power of the Physician's Wife" — Mrs. Lee Ann Elliott, Chicago, assistant director, American Medical Political Action Committee.

"What's Ahead in 1968" — Robert D. Novak, Washington, D. C., political columnist and co-producer of the syndicated column, "Inside Report."

"Working With Allies" — Roy Pfautch, St. Louis, president of Civic Service, Inc., who has handled publicity and promotion for various political candidates, including U. S. Senator Thomas Curtis.

"Tools and Aids Available for Candidate Support Committees" — James S. Imboden, Columbus,

American Medical Political Action Committee field representative.

"Yes, OMPAC Is an Important Factor in State Races" — Hart F. Page, Columbus, Executive Secretary, Ohio State Medical Association.

"Action At Once Imperative" — Blair J. Henningsgaard, M. D., Astoria, Oregon, chairman of the Board of Directors, American Medical Political Action Committee, and former president, Oregon Medical Association.

A question-answer period will be held if time allows. An effort will be made to conclude the conference at 3:00 P. M.

Doctors, Sports Authorities Warn Against "Spearing"

A group of coaches, physicians, and sports officials recently joined the American Medical Association in calling for an end to football "spearing."

Spearing is the tactic in which a blocker or tackler uses his head as a battering ram. It's dangerous, both for himself and for the person he hits, authorities warn.

The football authorities called for coaches to emphasize correct, head-up blocking and tackling, and for strict enforcement by officials of the rules against spearing.

When polled by the American Medical Association's Committee on the Medical Aspects of Sports, the group was unanimous in warning against spearing. The AMA committee asked for their comments when recent studies showed that head and neck injuries continue to constitute a very high percentage of serious injuries in football.

Said Notre Dame football coach Ara Parseghian: "I can't begin to tell the number of clinics where I have lectured on the (spearing) problem. We don't teach this at Notre Dame; and over the years, I have done everything within my power to influence others to coach against it."

when bursitis hits a 280-lb. tackle, hit back with Butazolidin alka



Indications: Osteoarthritis, rheumatoid arthritis, rheumatoid spondylitis, psoriatic arthritis, acute gout, painful shoulder (peritendinitis, capsulitis, bursitis and acute arthritis of that joint), acute superficial thrombophlebitis.

Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently. Large doses of Butazolidin alka are contraindicated in glaucoma.

Warning: If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with great caution in the first trimester of pregnancy.

Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools or other evidence of intestinal hemorrhage occur. Make regular blood counts. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The most common are nausea, edema and drug rash. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ul-

For 280-lb. tackles — or 108-lb. housewives — Butazolidin alka can hasten recovery from the agonizing pain of shoulder bursitis.

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And adverse reactions may occur. The most common are nausea, edema and rash. Rarely, agranulocytosis has been reported. All adverse reactions are listed below, too.

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cer and may reactivate a latent peptic ulcer. The patient should be instructed to take doses immediately before or after meals or with milk to minimize gastric upset. Mild drug rashes frequently subside with reduction of dosage. However, rash accompanied by fever or other systemic reactions usually requires withholding medication. Purpuric rash has also been reported. Agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome, or a generalized allergic reaction similar to serum sickness may occur and require permanent withdrawal of medication. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

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Dosage in painful shoulder: Initial: 3 to 6 capsules daily in 3 or 4 equal doses. Trial period: 1 week. Maintenance dosage should not exceed 4 capsules daily; response is often achieved with 1 or 2 capsules daily.

For complete details, please see full prescribing information.

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Outstanding Scientific Exhibits At OSMA Annual Meeting

ONE OF THE FEATURES at the 1967 OSMA Annual Meeting in Columbus, May 15-19 was the Scientific Exhibit and its companion Health Education Exhibit. From the many Scientific Exhibits on display the judging committee selected certain ones as outstanding. This procedure was in keeping with a recommendation of the Committee on Scientific Work approved by The Council. The authorized award in each case consists of a certificate of recognition, a permanent type plaque, and, in the case of the gold, silver, and bronze awards in the two fields of teaching and original investigation, monetary gift. A summary of exhibits selected to receive awards was printed in the July issue of *The Journal*, with four additional exhibits designated for honorable mention. Following are brief descriptions of two of the outstanding exhibits. Additional write-ups on other outstanding exhibits will be published in forthcoming issues of *The Journal*.

Exhibit on Laser Treatment Of Tattoos Recognized

Silver Award winner in the field of original investigation at the OSMA Annual Meeting was the exhibit entitled "Investigative Studies with Laser Treatment of Tattoos," sponsored by researchers of the Laser Laboratory, Children's Hospital Research Foundation, University of Cincinnati Medical Center. On the team were Leon Goldman, M. D., Karl W. Kitzmiller, M. D., Robert G. Wilson, M. D., James A. Eha, M. D., R. James Rockwell, Jr., M. Sc., and Robert Meyer.

The project is supported by grants from The John A. Hartford Foundation and the U. S. Public Health Service (No. OH-00118-04). The following description of the exhibit and the project was furnished by Dr. Goldman

The exhibit represents a summary of work over more than four years on the treatment of tattoos with the laser. The work was begun initially to attempt to study the mechanism of the laser reaction as regards absorption of color. It was found early in the course of laser research that those tissues which had color, for example like melanomas, showed significant destructive absorption of laser, whereas relatively colorless material showed much less. Vital dyes were used to study the reactions in transparent tissues and, then, the actual tattoos were used in animals such as the rabbit skin and the skin of the miniature pig.

With increasing concern about some of the hazards of the laser plume, the fragments being disseminated into local tissues or into the atmosphere, the tattoos in man were used also as a study of laser safety to show that pigment masses were not projected into adjacent areas from the tremendous impact of the laser.

To demonstrate how important was the specific wave length absorption of colors, studies were done to

show that with certain energy and power densities only the tattoo in the target area would show significant change; the adjacent tissues showing very little, if any, changes. As each new laser system was developed, its application to the treatment of tattoos was further studied. The Q-switching in which the laser impact has tremendous power in nanosecond time was shown to cause disappearance of the pigmented masses; with low power outputs, there was temporary disappearance; with high power outputs, significant disappearance of pigment masses were produced with minimal scarring. Extensive and basic studies on high output Q-switched ruby laser treatment of tattoos have been done by the Plastic Surgery Division of Stanford. Cooperative studies are now under way. It is assumed that the masses are transformed selectively into a gaseous phase. Many more studies will be needed with more selective laser impacts and combined treatment programs to develop a rapid and practical therapy for tattoos. These marks not only disfigure the skin but often the personality of the patient.

Honorable Mention Goes to Speech Clinic Exhibit

The exhibit entitled "A Language Retrieval Unit for Retraining Aphasic Individuals in Language" was designated for Honorable Mention in the field of original investigation. The exhibit was sponsored by John W. Black, Ph. D., professor of speech, and language project director, Ohio State University Research Foundation, Columbus.

Dr. Black provided *The Journal* with the following description of the exhibit and the research project.

The Language Retrieval Unit, which was designed and built at the Speech Science Laboratory, the Ohio State University, is used to assist aphasic patients to recover (retrieve) language. This unit and others



In the background is part of the exhibit, "Investigative Laser Studies on Removal of Tattoo Dyes," winner of the Silver Award in the field of original investigation at the 1967 OSA Annual Meeting, Dr. Lawrence C. Meredith, 1966-1967 OSA President, left, congratulates Robert Otten, technician in the Laser Laboratory, who helped man the exhibit. Mr. Otten is holding the silver award plaque. (See facing page for details.)



Honorable Mention in the field of Original Investigation was accorded the exhibit, "A Language Retrieval Unit for Retraining Aphasic Individuals in Language." Being congratulated by Dr. Meredith are William L. Dawson, left, and Deanna K. Marks, both associated with the retraining program for aphasics at Ohio State University. (See facing and following pages for details.)

of similar design have been used experimentally in the Columbus area, Dayton, Cleveland, and in Milan and Rome, Italy.

The reacquisition of speech and language requires the relearning of many skills. One of these skills is predictability. Normal speaking - listening adults rely on their ability to predict missing acoustic signals not heard because of noise interference, filtering (as in a telephone) or other reasons. For example, in the following sentence, th- bo- thr-w t-- ba--, one can predict (not guess) the missing letters accurately. Thus the patient is given the information bearing letters and the patient is required to supply the redundant letters.

Most aphasic patients lose the ability to predict well and any retraining of them for speech and language should include this important aspect. The Language Retrieval Unit can be programmed from simple to difficult material in a sequential manner thus enabling the speech clinician to measure the level at which the patient is functioning, start from that point and permit him to advance at his own pace.

This unit is programmed like an automatic typewriter. That is, when the machine is turned on, certain letters or phrases (information bearing material) will be typed out automatically then the unit will stop at the missing (redundant) letter. The patient must supply the missing letter or letters on an external peg board; if he is correct the instrument will continue until the next point of prediction; if incorrect, the correct letter will light up red to direct the patient's response. Thus, the patient cannot make two sequential errors.

The Language Retrieval Unit has been used in speech therapy for aphasic individuals in several places and has proved to be of valuable assistance to speech clinicians. The patients enjoy using it; they can use the instrument between therapy sessions and thus get daily practice and patients who use the instrument progress more rapidly than those who do not.

Dr. Michael Ogden, recently appointed chief of the newly formed Rural Health Branch, Division of Community Health Services of the U. S. Public Health Service, is a former Ohio resident and a graduate of Ohio State University College of Medicine, class of 1957.

The story of veterans' benefits, from earliest beginnings in 1636 to the current activities and programs of the Veterans Administration has been published in a 410-page volume, *Medical Care of Veterans*, available for \$1.25 through the U. S. Government Printing Office.

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Contraindications: Infants, patients with history of convulsive disorders, glaucoma or known hypersensitivity to drug.

Warning: Not of value in the treatment of psychotic patients, and should not be employed in lieu of appropriate treatment.

Precautions: Limit dosage to smallest effective amount in elderly or debilitated patients (not more than 1 mg, one or two times daily initially) to preclude ataxia or oversedation, increasing gradually as needed or tolerated. As is true of all CNS-acting drugs, until correct maintenance dosage is established, advise patients against possibly hazardous procedures requiring complete mental alertness or physical coordination. Driving during therapy not recommended. In general, concurrent use with other psychotropic agents is not recommended. If such combination therapy is used, carefully consider individual pharmacologic effects—particularly with known compounds which may potentiate action of Valium (diazepam), such as phenothiazines, barbiturates, MAO inhibitors and other antidepressants. Advise patients against simultaneous ingestion of alcohol or other CNS depressants. Safe use in pregnancy not established. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Observe usual precautions in impaired renal or hepatic function. Periodic blood counts and liver function tests advisable in long-term use. Cease therapy gradually.

Side Effects: Side effects (usually dose-related) are fatigue, drowsiness and ataxia. Also reported: mild nausea, dizziness, blurred vision, diplopia, headache, incontinence, slurred speech, tremor and skin rash; paradoxical reactions (excitement, depression, stimulation, sleep disturbances, acute hyperexcited states, hallucinations); changes in EEG patterns during and after drug treatment. Abrupt cessation after prolonged overdosage may produce withdrawal symptoms (convulsions, tremor, abdominal and muscle cramps, vomiting, sweating) similar to those seen with barbiturates, meprobamate and chlordiazepoxide HCl.

Dosage—Adults: Mild to moderate psychoneurotic reactions, 2 to 5 mg b.i.d. or t.i.d.; severe psychoneurotic reactions, 5 to 10 mg t.i.d. or q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; muscle spasm with cerebral palsy or athetosis, 2 to 10 mg t.i.d. or q.i.d. **Geriatric patients:** 1 or 2 mg/day initially, increase gradually as needed and tolerated. (See Precautions)

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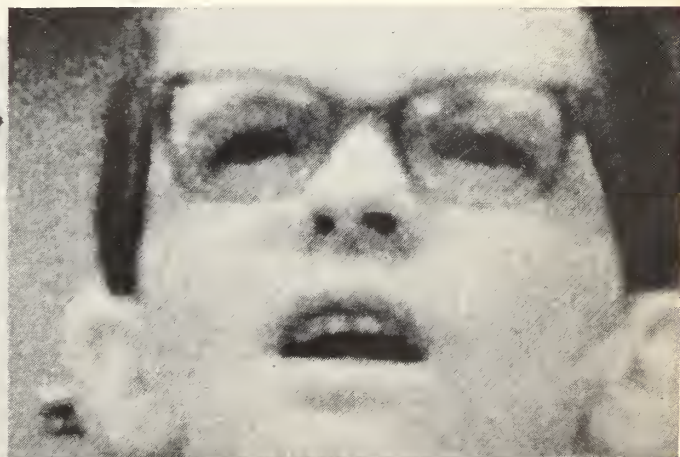
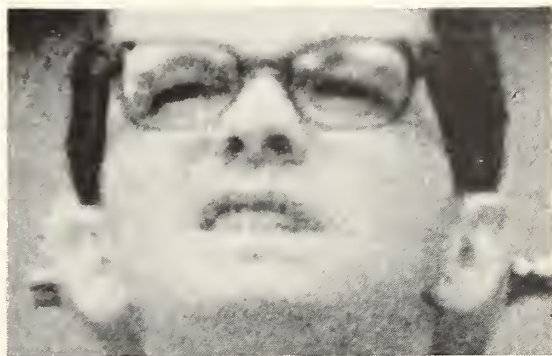


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Congress on Psychological Medicine . . .

Toledo Program, October 15; Dayton Program, October 29;
"The Many Faces of Depression" Will Be General Theme

THE SECOND Ohio Congress on Psychological Medicine will be conducted this fall on the basis of two regional conferences, one in Toledo on Sunday, October 15, and the other in Dayton on Sunday, October 29. General theme for the Congress is "The Many Faces of Depression."

The Congress is sponsored by the Ohio State Medical Association Committee on Mental Health, with the cosponsorship of the Ohio Psychiatric Association, the Ohio Academy of General Practice,

Toledo State College of Medicine Department of Psychiatry, and the Ohio State University Department of Psychiatry.

The Congress has been approved for 4½ hours of postgraduate credit by the American Academy of General Practice.

In both cities, registration opens at 9:30 A. M. (coffee furnished), with the first program feature at 10:00 o'clock. Programs run to 4:00 P. M.

Program at Toledo

Sunday, October 15

Academy of Medicine of Toledo

Welcome — Victor M. Victoroff, M. D., Cleveland, President Ohio Psychiatric Association.

Film — "The Mask of Depression"; moderator, B. L. Huffman, Jr., M. D., Toledo, President-Elect, Ohio Academy of General Practice.

Recognition of Depression in Adults — Henry L. Hartman, M. D., Toledo.

Recognition of Childhood Depression — Oscar B. Markey, M. D., Cleveland.

Panel Discussion — (participants in morning and afternoon programs).

Management of Depression in Children and Adolescents — William M. Easson, M. D., Toledo.

Management of Depression in Adults — L. Douglas Lenkoski, M. D., Cleveland.

Panel Discussion — (participants in morning and afternoon programs).

Program at Dayton

Sunday, October 29

Imperial House North

Welcome — Robert E. Howard, M. D., President, Ohio State Medical Association.

Film — "The Mask of Depression"; moderator, Wendell A. Butcher, M. D., Columbus, Chairman, OSMA Committee on Mental Health.

Recognition of Adult Depression — George J. Learmonth, M. D., Columbus.

Sources of Future Adult Depression as They Appear in Childhood — W. Hugh Missildine, M. D., Columbus.

Panel Discussion (Participants in morning and afternoon programs).

Management of Depression in Children — R. Dean Coddington, M. D., Columbus.

Management of Depression in Adults — Stanley L. Block, M. D., Cincinnati.

Panel Discussion — (Participants in morning and afternoon programs).

SECOND OHIO CONGRESS ON PSYCHOLOGICAL MEDICINE "The Many Faces of Depression"

Check One: \$10.00 Per Person (includes luncheon)

☐ October 15, at Toledo Academy of Medicine, 3101 Collingwood Blvd., Toledo

☐ October 29, Imperial House North, Dayton, Ohio on Interstate 75 just south of Interstate 70

Registrant's Name

Address

Make Checks payable to: Second Ohio Congress on Psychological Medicine.

Mail to:

Ohio State Medical Association
17 South High Street, Suite 500
Columbus, Ohio 43215

Ohio Medical Indemnity Makes Its 21st Annual Report

Ohio Medical Indemnity, Inc., Ohio's Blue Shield Plan serving 83 Ohio Counties, attained an all-time high number of subscribers — 2,725,942 — in 1966, representing a gain of 244,133 persons covered, it was reported at the 21st annual meeting of the stockholders held at the company's headquarters offices, 3770 North High Street, Columbus.

In the year 1966, OMI completed 21 years of service to the people of Ohio and the general reserve reached \$21 million.

The company reached another all-time high on December 31, with earned subscription income of \$40,069,000. This is \$6 million over the 1965 figure and \$10 million over the 1964 figure.

Enrollment as of the end of the year also was at an all-time high of 2,725,942 subscribers.

Because of the increased work load, the number of employees was increased to 131 during the year.

Officers re-elected by the Board of Directors following the stockholders' meeting were: President, Edmond K. Yantes, M.D., Wilmington, general practitioner; First Vice-President, Starling C. Yinger, M.D., Springfield, ENT specialist; Executive Vice-President, Charles H. Coghlan, Columbus; Treasurer, Dwight L. Becker, M.D., Lima, general practitioner;

Vice-President-Administration, Secretary and Assistant Treasurer, Frank W. Van Holte, Columbus.

Two new members of the Board of Directors, elected by the stockholders, were: John R. Meek, M.D., Cincinnati, surgeon, and M. M. Thompson, M.D., Toledo, roentgenologist.

Members of the Board re-elected were: Ralph L. Abernathy, Dayton, division superintendent, Ohio Bell Telephone Company; William T. Blair, Columbus, director of social legislation and industrial development, Ohio Chamber of Commerce; J. Martin Byers, M.D., Columbus, assistant medical director, North American Aviation Company; Nino M. Camardese, M.D., Norwalk, general practitioner; H. M. Clodfelter, M.D., Columbus, internist; Clair E. Fultz, Columbus, president, Huntington National Bank; Lloyd E. Larrick, administrator, Christ Hospital, Cincinnati; Robert S. Martin, M.D., Zanesville, specialist in EENT; J. A. Meckstroth, Columbus, editor-emeritus, *Ohio State Journal*; Howard C. Sauer, Canton, retired general manager, Over-Seas Division, Timken Roller Bearing Company; Frank L. Shively, Jr. M.D. Dayton, surgeon; Harold W. Slabaugh, Akron, attorney; Msgr. John C. Staunton, Cincinnati; Gordon M. Todd, M.D., Toledo, internist; William A. White, Jr., M.D., Canton, internist; Francis M. Wistert, Vice-President, Eltra Corporation, Toledo; and Drs. Yantes, Becker and Yinger.

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Physicians, Drugs, and the Law . . .

Physicians' Obligations in Regard to Keeping Certain Records of Drugs Regulated by Federal and State Laws

FOLLOWING IS A ROUNDUP ARTICLE intended to give physicians current basic information on federal and state laws pertaining to certain drugs, particularly in regard to the keeping of records. The generous help of Frank E. Kunkel, Executive Secretary of the Ohio Board of Pharmacy, in the preparation of the article is acknowledged.

* * *

OHIO DRUG LAWS are somewhat unique in that enforcement of their provisions, at the pharmacy and physician's office level, is delegated by the Legislature almost exclusively to the State Board of Pharmacy. This is in contrast to the custom in many other states in which the authority may be divided between the department of health and the department of agriculture. In more than one state there is established a special bureau which inspects pharmacies, barber shops, physicians' offices, cosmetic parlors, and taverns indiscriminately from a pool of versatile inspectors supposedly knowledgeable in all areas of law enforcement.

The Ohio State Board of Pharmacy field staff presently consists of seven inspectors under a chief. It is soon to be augmented by the addition of two registered pharmacists. The lay inspectors make routine inspections of all licensed distributors of drugs. The Board proposes to reserve activities of the pharmacists primarily for the purposes of education in drug distribution and record keeping in hospitals, extended-care facilities, and wherever professional medical services are rendered.

Ohio's Dangerous Drug Law controls legend drugs from the moment they enter the borders of the state until they reach the ultimate consumer by a system of registration of all legal distributors, including manufacturers, wholesalers, and retail or terminal outlets. This law has become a model for similar statutes in states throughout the country.

Physicians are exempted from most of Ohio's drug distribution laws, however, the same requirements applied to pharmacists exist under certain circumstances for the physician using narcotics, barbiturates, or stimulants in his practice. From information brought to the board's attention, it is apparent that these phases of the law are not generally known, and it is

possible that some physicians may be innocently laying themselves open to serious legal problems by office procedures different from those required by law.

With the arrival of the new Federal Food and Drug Administration Drug Abuse Control Amendments, there has been an increase in inquiries by physicians with respect to their legal obligation in drug record keeping. This article is a generalization, not only in regard to the Drug Abuse Control Amendments, but to all areas of concern in the dispensing or administering of certain drugs.

The laws governing the use of drugs by physicians are relatively few and simple. Information under the following headings are presented with the intention of providing at least minimum legal requirements.

Narcotics

1. A physician may purchase narcotic drugs for use in his practice only by ordering them on a Federal Narcotic Requisition form.

- A. It is illegal to issue a narcotic prescription for a patient and use the narcotic drug on anyone other than that patient.

2. Every physician authorized to use narcotic drugs by registering with the Federal Narcotics Division, shall keep records of all narcotic drugs received, administered, dispensed or used, which record shall contain:

- A. A description of all narcotic drugs received, the quantity received, the name and address from whom received, and the date of receipt. (The carbon copy of the Federal Narcotic Requisition and the invoice from the supplier meet this requirement.)

- B. The kind and quantity of narcotic drugs administered, dispensed, or used, the date of administering, dispensing, or using, the name and address of the person to whom or for whose use the drug was administered, dispensed, or used. (The completed patient office record meets this requirement.)

3. The Class A narcotic drug may be prescribed only by a written prescription bearing the signature

of the prescriber and the date it was signed, the full name and address of the patient for whom it has been issued as well as the full name, address, and federal narcotic registry number of the physician prescribing.

This requirement frequently presents a difficult problem to the pharmacist faced with a telephone order for Class A narcotics by a physician whose good will is desirable and not likely to be maintained if his narcotic prescribing habit is challenged.

4. The law permits someone other than the physician to administer narcotic drugs provided administration is under his direction and supervision.

It does not permit anyone other than the physician to dispense or prescribe narcotic drugs.

5. All narcotic drug records must be kept two years.

Barbiturates

1. A practitioner is required to keep a record of all barbiturates dispensed or professionally used by him otherwise than by prescription for not less than two years.

2. This record need not be kept when the amount administered, dispensed, or professionally used in the treatment of any one patient does not exceed 12 grains in any 48 consecutive hours.

3. Where a physician in the course of his practice dispenses barbiturates, the immediate container of such drugs shall bear a label on which appears the name and address of the patient, name and address of the prescriber, and directions for use.

Drug Abuse Amendments

Since February 1, 1966, stimulants and depressants and many combinations thereof have been controlled by the Federal Food and Drug Administration Drug Abuse Control Amendments of 1965.

A physician who regularly engages in dispensing these drugs to his patients and charges, either separately or together with charges for other professional services, is subject to the record-keeping provisions of these amendments. These records include a complete inventory of stock on hand, a record of receipts of additional supplies, complete record of the kind of drug, quantity dispensed, to whom dispensed, and the date of dispensing. These records must be kept for three years and are open to inspection by both state and federal authorities.

Ohio has recently completed an arrangement whereby enforcement of these amendments will be confined to the Ohio Board of Pharmacy except in the case of any large scale diversion of these drugs.

It must be stressed that the concept of cooperation between officers of the State Board of Pharmacy

and federal law enforcement agents in regard to certain drug regulations is one of long standing, and is spelled out in Chapter 3719 of the Ohio Revised Code. The recent agreement between the state board and the federal government in regard to the Drug Abuse Control Amendments is merely an extension of this concept to include provisions of the new law.

Pharmacist records are reviewed periodically by Pharmacy Board inspectors and physician's office records are subject to similar inspection whenever there is reason to believe they are incomplete or inadequate. A Board of Pharmacy official points out that these inspections are not intended to be punitive, but rather educational and instructive. Board inspectors are instructed to help, not hinder physicians in the legal practice of their profession.

Pharmacy has been reported to be the most regulated, supervised, and inspected profession in the health field. For that reason most pharmacists are thoroughly trained in keeping records in compliance with the law. Board of Pharmacy representatives are trained to explain legal record-keeping requirements and can be helpful in setting up procedures which comply with the law. Physicians are invited to call upon the Board of Pharmacy representatives to help them in meeting their legal obligations. Many physicians also will find local pharmacists, or representatives of drug firms, willing and able to help in this field.

"Drug Abuse Drugs"

Public Law 89-74, the Drug Abuse Control Amendments of 1965, went into effect February 1, 1966, with a temporary exemption for certain drugs in combination form. The temporary exemption expired on April 1, 1967. The federal law is aimed at curbing drug abuse through curtailment of illicit traffic in certain drugs. Barbiturates and amphetamines are specifically named, but the law applies also to other drugs classed as stimulants and depressants.

A long list of drugs exempted under the law by the Food and Drug Administration was published in the Federal Register of January 10, 1967. Additional lists of exempted drugs are published from time to time, and, technically, any drug product containing any of the stimulant or depressant substances which does not appear on the exemption lists falls under the Drug Abuse Control Amendments regulations.

The American Pharmaceutical Association has compiled a list of stimulant and depressant drugs for which pharmacists, and physicians who dispense drugs, must maintain records under requirements

of the Drug Abuse Control Amendments. Supplementary lists are published from time to time.

For practical purposes the original list published by the American Pharmaceutical Association late in 1966 is the best guide for physicians in practice. As a matter of fact, a representative of the State

Board of Pharmacy has recommended this listing as a guide. Except in unusual cases, use of this list as a guide in keeping records would demonstrate the physician's intent to comply with the law.

The list is as follows:

A

Actemin
Ad-Nil (Medics)
Adrizine (Key)
Aktedron
Alentol
Allobarbitol
Allobarbitone
*Allylbarbituric acid
*Allylisobutylbarbituric acid
*Allylisopropylbarbituric acid
*Allylisopropylmalonylurea
Alurate (Roche)
Ambar (Robins)
Am-Dex (Superior)
Amfebarbs (Gold Leaf)
Amerital (Merit)
d-Amfetazol (Pitman)
Amitrene (Normand)
*Amobarbital
Amobarbital Sodium
Amodex (Testagar)
Amo-Dextrosule (Arnar-Stone)
Amo-Dexules (Recsei)
Amondex (Testagar)
Amo-Pellcaps (Kirkman)
Apamine (Stillco)
Amphaplex (Palmedico)
Ampharb (Harvey)
Amphate (Storck)
Amphedrine (Van Pelt & Brown)
Amphedrine-M (Van Pelt & Brown)
Amphedroxyn (Libby)
Ampherex (Royce)
Am-Phet (Paul Maney)
Am-Phet Unoday Ph. 758
(Paul Maney)
*Amphetamine
d-Amphetamine Carboxy-
methylcellulose Salt
l-Amphetamine Alginate
Amphetamine Hydrochloride
*Amphetamine Phosphate
*Amphetamine Phosphate,
Dibasic
Amphetamine Resin Complex
*Amphetamine Sulfate
Amphetamine Tannate
Amphex (Algro)
Amphoids-S (Gold Leaf)
Amsustain (Key)
Amvicel (Stuart)
Amylofene (First Texas)
Amytal (Lilly)
Amytal Sodium (Lilly)
*Aprobarbital
Arcodex (Arcum)

B

Barbenyl
Barbiphenyl
Barbipil (Chicago Pharm.)
Barbita (Chicago Pharm.)
*Barbital
*Barbitone
Barbivis (Chicago Pharm.)
Barbosec (Rowell)
Bar-Dex (Barre)
Benzobar (SK&F)

Benzedrine (SK&F)
Benzedrine Sulfate (SK&F)
Beta-Chlor (Mead-Johnson)
Betafedrine
d-Betaphedrine
Biphetamine (Strassenburgh)
Blu-phen (Lemmon)
Bontril (Carnick)
Brevital Sodium (Lilly)
*Bromoalyl sec-amylbarbituric acid
Bubartal Sodium (Phillips Roxane)
*Butabarbitol
*Butabarbitol Sodium
Butabarpal (Phila. Ampoule)
Butalbitol
*Butallylonal
Butazem (Zemmer)
*Butethal
Butisol Sodium (McNeil)

C

Calcium Cyclobarbitol
Calcium Pentobarbital
Calcium Probarbital
Cendex (Central)
Cendexal (Central)
*Chloral betaine
*Chlorhexadol
*Chloral Hydrate
Cradex (Craig)
Curral
*Cyclobarbitol
Cyclobarbitone
Cyclonal Sodium (May & Baker)
Cylcopal (Upjohn)
Cyclopen (Massengill)
Cydril (Tutag)

D

Dadox (Central)
Daro (Testagar)
D.A.S. (Stayner)
D-Ate Ph 747 (Paul Maney)
D-Citramine (Preston)
Deba
Delfetamine
Delfeta-Sed
Delfetaset-tabs
Deltolate (Mallard)
Delvinal (MS&D)
Delvinal Sodium (MS&D)
Deofed (Drug Products)
Desamine (Starr)
Desoxo-5 (Sutliff & Case)
Desoxedrine (Testagar)
Desoxyn (Abbott)
Desoxyephedrine & their salts
Detrex (Mallard)
Desbutal (Abbott)
Desyphed (Winthrop)
Dexabar (Myers Carter)
Dexabarb (Nysco)
Dexadur (Wynn)
Dexalme (Meyer)
Dexalme L. A. (Meyer)
Dexalone (Wynn)
Dexamphetamine
Dexamyl (SK&F)

Dexaphet (Domed)
Dexaslim (Domed)
Dexatal (Wynn)
Dexedrine Sulfate (SK&F)
Dexibar (Barre)
Dexibar-B (Barre)
Dex-OB (Tully)
Dexoval (Vale)
Dex-Sed (Carrtone)
Dexstim (Central)
Dex-Sules (Normal)
Dexten
*Dextroamphetamine Carboxy-
methylcellulose Salt
Dextroamphetamine Hydrochloride
*Dextroamphetamine
Phosphate
*Dextroamphetamine
Phosphate, Dibasic
*Dextroamphetamine Sulfate
*Dextroamphetamine Tannate
Dextrobar (Lannet)
Dextrolen (Len-Tag)
Dextro-Profetamine (Clark & Clark)
Dextrosule (Amar-Stone)
Dextra Unicells (Hiss)
Dexules (Recsei)
Diadol (Buffington)
Dial (Ciba)
*Diallylbarbituric acid
Dietamine (Key)
*Diethylbarbituric acid
*Diethylmalonylurea
*Dimethyltrptamine
Diocurb (Tutag)
Diphetamine (Tutag)
*Dipropylbarbituric acid
*DMT
D-O-E (Breon)
Domafate
Dorico Soluble
Doriden (Ciba)
Dormiral
Dormonal
Doxyfed (Raymer)
Drinalpha (Squibb)
Dura Dex (Bonar)

E

Efroline (Strassenburgh)
844
Eldoral
Elpandryl (Elder)
Embutal
En-Chlor (Ulmer)
Eskabarb (SK&F)
*Ethchlorvynol
*Ethinimate
Ethobral (Wyeth)
Etoval
Eunarcon
Euneryl
Evipal (Winthrop)
Evipal Sodium (Winthrop)
Evipal Sodium
Evrodex (Evron)
Evronal Sodium (Evron)

* The asterisk indicates nonproprietary or generic name.

F-G

Felsules (Fellows-Testagar)
Gardenal
Gemonil (Abbott)
*Glutethimide

H

Halcotabs
Hebaral
Heptabarbital
Hetamine (Dumas-Wilson)
Hexanastab
*Hexethal Sodium
Hexobarbital
*Hexobarbital Sodium
Hexobarbitone Sodium
Hydral (Person & Covey)
Hypnoderm (Massengill)
Hypnogene

I-K

Insolat (Denab)
Intasedol (Elder)
Intraval Sodium
Ipral (Squibb)
Ipral Calcium (Squibb)
Ipral Sodium (Squibb)
Itobarbital
Kessodrate (McKesson-Robbins)

L

Lanazine (Lannett)
Lavabo (Superior)
Levamphetamine
*Levoamphetamine Alginate
*Levoamphetamine Succinate
Levonor (Nordson)
Linampheta (Lincoln)
Lora (Wallace Labs)
Lorinal (Amar-Stone)
Lotusate (Winthrop)
Lowdex CTR (Lowe)
*LSD
*LSD 25
Luminal (Winthrop)
Luminal Sodium (Winthrop)
Lycoral (Fellow-Testagar)
*Lysergic Acid
*Lysergic Acid Amide
*Lysergic Acid Diethylamide

M

Malonal
Maxiton
Mebaral (Winthrop)
Mebutal (Medco)
Medex (Medco)
Medinal (Warner)
Medomin (Geigy)
*Mephobarbital
*Mescaline & its salts
*Methamphetamine & their salts
Methaphin (Rorer)
Metharbital
Methedrine HCl (Burroughs-Wellcome)
*Methypylon
Methoxyn (Kenny Pharm.)
Methenexyl Sodium
Methohexital Sodium
Miller-Drine (Miller)
Monophos (Tilden Yates)

N

Nactisol
Namuron (Winthrop)
Napental (Massengill)
Napethal
Narconumal
Nembutal (Abbott)
Nembutal Calcium (Abbott)
Nembutal Sodium (Abbott)
Neonal (Abbott)
Nesdonal Sodium
Neurobarb
Nidar (Armour)
Nilox (Direct Labs)
Noctal
Noludar (Roche)
Normadrine Solution
Norodin (Endo)
Nostal
Notec (Squibb)
Numal (United Chemicals)
Nunol

O

Obesedrin
Obesonil (Lincoln)
Obetral (Obetral)
Obocell
Ortal Sodium (Parke, Davis)
Oxydess (Chimedix)
Oxydrin (Grant)
Oxyfed (Cole)

P

Paral (Fellows-Testagar)
*Paraldehyde
Pellbarb (Kirkman)
Pellcaps (Kirkman)
Pental (Ven Pelt & Brown)
Pentalen
Pentobarbital
*Pentobarbital Sodium
Pentothal Sodium (Abbott)
Pentyl
Periclor (Ives)
Pernocton
Pernoston
*Petriclhoral
*Peyote
Phanadorm
Phanodorn Calcium (Winthrop)
Phedoxe 4B (Elder)
Phedrisox (Ascher)
Phemitone
*Phenmetrazine and its salts
*Phenobarbital
Phenobarbital Sodium
*Phenobarbitone
Phenonyl
*Phenylethylmalonylurea
*Phenylmethylbartitric acid
Phetobese (Cole)
Phob (Brewer)
Placidyl (Abbott)
Pomadex (Standex)
Preludin (Geigy)
Premodrin (Premo)
*Probarbital
Probarbital Sodium
d-Profetamine Phosphate
(Clark & Clark)
Prominal
*Propallylonal
Proponal
*Psilocibin
*Psilocin
Psychotone (Davon Pharmacal)

Q-R

Q Caps (Testagar)
R 239
*Racephen (Ives-Cameron)
Raphetamine Phosphate
(Strasenburgh)
Rectidon
Rectules (Fellows-Testagar)
Rutonal

S

Sandoptal (Sandoz)
*Secobarbital Sodium
Secodex (Nysco, Hart)
Secodrin (Premo)
Seconal Sodium (Lilly)
Seco-Synatan (Neisler)
Sedeval
Sedex (Nysco)
Sedobarb (Whittier)
Semoxydrine (Massengill)
Sigmodal
Simpamina-D
Soluble Barbital
*Soluble Pentobarbital
Soluble Phenobarbital
*Soluble Secobarbital
Sombulex (Schenley)
Somnalert (Warren-Teed)
Somnos (MSD)
Somnos Elixir (MSD)
Somonal
Somtrol (Columbus)
Soneryl
Span-RD (Metro Med)
Stental (Robins)
Stimdex (Ulmer)
Sulfonal
*Sulfondiethylmethane
*Sulfonethylmethane
*Sulfonmethane
Surital Sodium (Parke, Davis)
Sympamin
Synatan (Irwin, Neisler)
Synate (Central)
Syndrox (McNeil)
Syntil (McNeil)

T

Talbutal
Tanphetamine
Teolaxin (Paul Maney)
Tetrahydrophenobarbital
Tetronal
Thiamylal Sodium
*Thiopental Sodium
*Thiopentone Sodium
Thiothal Sodium
Tri-Dex (Testagar)
Trional
Trinal (Lilly)
Tydex (Tyler)
Tydex-Plus (Tyler)

U-V-Z

Uronal
Valmid (Lilly)
Veronal
Vesperial
*Vinbarbital
Vinbarbital Sodium
Zamitam (Marion)
Zamitol (Marion)

* The asterisk indicates nonproprietary or generic name.

Symposium on Diabetes Scheduled In Columbus on October 4

The Fourth Annual Professional Symposium on Diabetes sponsored jointly by the Central Ohio Diabetes Association and the Ohio State University College of Medicine has been scheduled for Wednesday, October 4, at the Sheraton-Columbus Motor Hotel in downtown Columbus.

Theme for the scientific program is, "Diabetes Mellitus: Past, Present, Future." Registration opens at 8:30 A.M., with the first program feature at 9:00 A.M. Advance registration may be made with The Center for Continuing Medical Education, A-352 Starling-Loving Hall, 320 West Tenth Avenue, Columbus, Ohio 43210; fee, \$20.

The final scientific feature is scheduled at 3:00 P.M. A program of laymen will be sponsored by the Diabetes Association at the Columbus Gallery of Fine Arts, beginning at 8:00 P.M. The program will include appearance of the guest faculty.

The scientific program has been announced as follows:

Welcome — Richard L. Fulton, M.D., President of the Central Ohio Diabetes Association; clinical associate professor of medicine, OSU; and James V. Warren, M.D., professor and chairman of the Department of Medicine at OSU.

Diabetes in Juveniles — Thomas G. Skillman, M.D., professor and director of the Division of Endocrinology and Metabolism, OSU.

Growth Hormones — Roger H. Unger, M.D., associate professor of internal medicine, University of Texas Southwestern Medical School, and director of research for the Veterans Administration Hospital, Dallas.

George J. Hamwi Memorial Lecture on "The Effects and Actions of Insulin" — Rachmiel Levine,

M.D., professor and chairman of the Department of Medicine, New York Medical College.

Panel Discussion — Moderator, Thomas P. Sharkey, M.D., Dayton, clinical assistant professor of medicine, OSU.

Afternoon Program

Insulin Assays — David M. Kipnis, M.D., professor of medicine, Washington University School of Medicine, St. Louis.

Diabetes in Pregnancy — Max Miller, M.D., professor of medicine, Western Reserve University School of Medicine, Cleveland.

Panel Discussion — Moderator, Dr. Sharkey.

Rehabilitation Group Conference, Cleveland, October 2-4

The National Rehabilitation Association is presenting the 1967 NRA Conference in Cleveland, Monday-Wednesday, October 2-4, with the program theme, "The Many Faces of Rehabilitation." Meeting place is the Sheraton-Cleveland Hotel. Board and committee meetings will be held on Saturday and Sunday preceding the conference.

Highlight topics to be presented by outstanding speakers will include the following: The Prophetic Mission of Rehabilitation — Curse or Blessing? Learning Disabled Roles; The Rehabilitation Agency and Problems It Creates for Its Clients; Programmed Instruction Techniques for the Mentally Retarded Child; The Client's Relations with Others; Assessment and Evaluation of Change in Behavior of the Rehabilitate; The Application of Behavior Therapy Principles to Problems of Mentally Retarded and Autistic Children.

Details may be obtained from the National Rehabilitation Association, Conference Headquarters, 2239 East 55th Street, Cleveland, Ohio 44103.



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Ten Years of Progress with OSSMA...

Here Is How Many Medical Assistants in Ohio Are Improving Their Abilities to Serve Doctors. OSSMA Can Help You Too

THE Ohio State Society of Medical Assistants had its beginning ten years ago in Toledo, when 80 medical assistants from all parts of the state met with a common goal in their determination, "to render honest, loyal, and more efficient service to the medical profession and to the public which it serves."

Since its beginning, under the capable guidance of an Advisory Committee of the Ohio State Medical Association, the group has grown slowly but steadily and has demonstrated its ability to promote a spirit of service and loyalty among its members.

What can the Ohio State Society of Medical Assistants do for your medical assistant, Doctor . . . and for you?

Here are some pointers:

- OSSMA is basically an educational organization, directed toward helping the medical assistant to become more efficient and to promote a smooth running office.

- One of its principles teaches members to demonstrate honesty, loyalty, and competency in all of their duties.

- Members are urged to cooperate with their employers in the ever-present task of improving public relations for the doctor and for the medical profession as a whole.

- Loyalty goes beyond professional responsibilities and the office-hour schedule. For example, in virtually every Ohio county where physicians sponsored Sabin oral vaccine programs, medical assistants rendered valuable help.

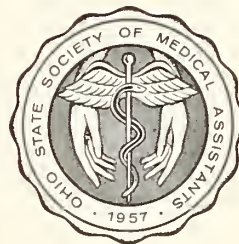
- According to its constitution and bylaws, OSSMA may not become affiliated with any other organization without the approval of the Ohio State Medical Association.

- The organization IS NOT and SHALL NOT be used as a collective bargaining agent for its members in regard to matters pertaining to their employment.

- Certification standards for membership have been set up and tests are given regularly by the

American Association of Medical Assistants. Leading colleges are affiliated with the certification program.

- Programs at county and state level meetings included such practical subjects as the following: Emergencies in the office; how to fill out insurance



forms; better telephone techniques; medical-legal involvements; billing, credit, and collection procedures; and so forth. Numerous seminars have been held regarding Medicare and other governmental programs as they relate to the physician's practice.

- Various specialists are invited to lecture to medical assistants on procedures in every phase of medicine.

- In short, the medical assistant often sets the stage for the doctor's image in the eyes of the patients. Such responsibility takes constant training, and OSSMA helps her acquire that training.

Physicians are invited to discuss the merits of this organization with their medical assistants, and may feel free to direct questions to the Advisory Committee in care of the OSSMA Headquarters Office.

Physicians and medical assistants are urged to correspond with the Ohio State Society of Medical Assistants. Membership Chairman is Mrs. Wilda Haines, Aultman Hospital, 2600 Sixth Street, S.W., Canton, Ohio 44710. The President is Miss Laura L. Lockhart, 21 South Highland Avenue, Apt. 6, Akron, Ohio 44303.

Watch future issues of *The Journal* for additional information on this important subject.

Adolescent Problems To Be Theme At Huntington Symposium

Physicians of Southern Ohio in particular, (and other physicians interested) have a special invitation to attend the 13th Annual Symposium sponsored by the Cabell County Medical Society in Huntington, West Virginia, on Thursday, September 14. The place is the Hotel Frederick, Fourth Avenue and Tenth Street, with the program starting at 9:00 A. M.

Theme of the program is "Problems of the Adolescent." One of the guest participants is Dr. Thomas E. Shaffer, Columbus, who has been active in school health and athletic injury programs on the state and national levels.

Program chairman is David A. Haught, M.D., First Huntington National Bank Building, Huntington.

Guest participants and their subjects are the following:

C. Andrew Rigg, M.D., Childrens Hospital of the District of Columbia — **Some Normals and Abnormals in Adolescent Growth and Development.**

Warren R. Lang, M.D., Jefferson Medical College, Philadelphia — **Menstrual Disorders of the Adolescent.**

Thomas E. Shaffer, M.D., Department of Pediatrics,

Ohio State University College of Medicine, Columbus — **The Adolescent Athlete.**

Edward M. Litin, M.D., Department of Psychiatry, Mayo Clinic, Rochester, Minn. — **Emotional Problems of the Adolescent.**

Ohio General Practitioners Elect Officers at Columbus Assembly

Dr. B. Leslie Huffman, Jr., Toledo, was installed as president of the Ohio Academy of General Practice, at the organization's annual assembly in Columbus, August 1-3. He succeeds Dr. Benjamin W. Gilliotte, of Zanesville.

Other new officers installed were Doctors George D. Clouse, Columbus, president-elect; Robert S. Young, Johnstown, vice-president; Walter G. Engel, Cincinnati, vice-president; David A. Barr, Lima, treasurer; Fred V. Light, Cleveland, speaker; Sanford Press, Steubenville, vice-speaker; Roger A. Peatee, Bowling Green, AAGP delegate; and Benjamin W. Gilliotte, Zanesville, AAGP alternate. Newly elected directors were Drs. Kenneth Frederick, Cincinnati; Alford C. Diller, Convoy; Harry A. Killian, Wiloughby; Crist Strovilas, Toronto; Harry Nenni, Ironton; James C. Good, Columbus; and Richard W. Reiman, Wooster.

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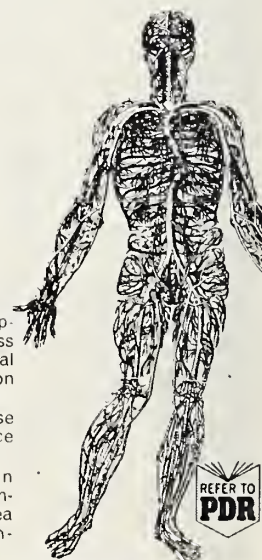
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Vital Statistics for Ohio ...

Ohio Department of Health Issues Annual Report for 1966 Showing Data as Compiled by Division of Vital Statistics

THE Ohio Department of Health, Division of Vital Statistics, recently issued its annual report for 1966 showing data compiled from original certificates of live birth, fetal death, and death, and from abstracts of marriage and divorce registered with the Division. A narrative description summarizing information precedes detailed tables giving information by counties, etc. Following are excerpts from the report.

Population

Ohio Department of Development estimates of population placed the State's resident total at 10,691,488 as of July 1, 1966, and this figure represented an increase of 127,344 or 1.2 per cent over the estimate of 10,564,144 for July 1, 1965.

This 1966 midyear estimate for the State, as well as similar estimates for counties and cities, were used to compute all rates based on population shown in this report.

Live Births

Number and Rate: The number of live children born to resident mothers of Ohio declined for the ninth consecutive year, to a final 1966 total of 190,444, down 4,483 from 1965, and down 22,139—more than 10 per cent, since 1963. The 1966 figure was the smallest since 1950, and the corresponding live birth rate reached a 25 year low of 17.8 per 1,000 population. Not since the war year of 1941 has it been near this level, when the rate was 17.7 per 1,000 population.

Natural Increase: For the calendar year 1966, the natural population increase (excess of births over deaths) was 91,523, giving a rate of increase of 8.6 per 1,000 population. Corresponding white and nonwhite rates were 8.1 and 14.0 per 1,000 population respectively.

Sex Ratio: The sex ratio at birth remained relatively the same, as the ratio was 1,060 males for every 1,000 females in 1966, compared to 1965 figures of 1,043 males per 1,000 females.

Race: White births totaled 169,549 in 1966, or about 89 per cent of all births, and this was a decrease of 4,365 from 1965. Nonwhite births also

showed a slight decline in number, as indicated by totals of 21,013 in 1965 and 20,895 for the past year. Rates also moved downward, with a white rate of 17.3 per 1,000 white population for 1966, compared to 17.9 in 1965, and 1966 nonwhite rate of 23.8 per 1,000 nonwhite population, against 24.2 the previous year. The 1966 nonwhite rate was nearly 38 per cent higher than the white rate, moderately above the 1965 differential.

Plurality: In 1966, there were 186,596 single and 3,848 plural resident live births in Ohio; the latter figure included 3,814 twin deliveries and 34 of higher orders. The resultant plurality rate of 20.2 per 1,000 live births was similar to the rate of 20.6 for the previous year.

Birth Order: First and second births increased in number from 1965 to 1966, with first births continuing an upward trend that has been evident since 1962. Second births, however, had been declining in number since 1956, when tabulated data by birth order first became available. Births in higher orders continued downward.

Age of Mother: Younger mothers continued to give birth to increasing numbers of children, as those born to women under 20 years of age totaled 31,716, nearly 17 per cent of all births. Births to mothers in this age group have risen in both number and as a percentage of all births since 1963, in the face of a marked decline in overall birth totals. Births to mothers aged 20-24 accounted for 36 per cent of the total, while those in the 25-29 bracket represented 25 per cent.

Illegitimacy: Births to unwed mothers increased in Ohio, as in the nation. Although the number of live births to resident mothers of Ohio decreased, the live births to unwed mothers increased 4.8 per cent—from 13,282 in 1965 to 13,924 in 1966. The illegitimacy ratio of 73.1 per 1,000 live births in 1966, represents a 7.3 per cent increase over the 68.1 illegitimacy ratio in 1965.

Nearly 49 per cent of the 13,924 illegitimate children were born to mothers under 20 years of age, while only 14 per cent of the 176,520 legitimate births involved mothers in this age group. Of the 31,716 total births to mothers under 20 years

of age, 6,771 (about one of every five) were illegitimate.

Prematurity: Premature births, those with a birth weight of 5 pounds, 8 ounces (2,500 grams) or less, totaled 15,087 or 7.9 per cent of all Ohio resident live births in 1966. The premature birth rate of 79.2 per 1,000 live births was unchanged from 1965.

Deaths

Fetal Deaths: In 1966, the number of resident fetal deaths reported was 2,659, down 38 from 1965. The resultant fetal death rate of 14.0 per 1,000 live births was similar to those for the last several years.

Infant Deaths: Ohio's resident infant deaths decreased from 4,346 in 1965 to 4,066 in 1966. The infant death rate also declined as it dropped to 21.4 per 1,000 live births, as compared to 22.3 in 1965. This 1966 rate was the lowest on record in Ohio, with the best previous figure being posted in 1964, when the rate was 22.0. Both white and nonwhite rates also reached new lows, at 19.8 and 33.9 deaths per 1,000 live births respectively.

Major causes of infant mortality included diseases peculiar to early infancy, which totaled 2,562 or 63 per cent of all deaths, congenital malformations with 708 deaths, diseases of the respiratory system with 407, and accidents, with 129.

Neonatal Deaths: Neonatal deaths (those occurring within the first 27 days of life) totaled 3,095 in 1966, or 76.1 per cent of all infant deaths. Comparable figures for 1965 were 3,217 representing 74 per cent of the infant deaths.

Maternal Deaths: In Ohio, the 49 maternal deaths in 1966 resulted in a resident maternal death rate of 2.6 per 10,000 live births. While the number of deaths rose from 43 in 1965, this total represented the second fewest number of maternal deaths in Ohio's history. Figures for 10 year intervals were 511 (recorded) in 1936, 204 in 1946, and 95 in 1956, clearly depicting the dramatic improvement we have realized.

All Causes: Resident deaths from all causes totaled 98,921 in 1966, which was an increase of 629 over the 1965 total of 98,292. The crude death rate, at 9.3 per 1,000 population, has not changed since 1964.

Leading Causes: The leading cause of death in 1966 was heart disease, as it has been for many years. A total of 39,520, or 40 per cent of all deaths resulted from this cause alone. The heart death rate was 369.6 per 100,000 population, compared to a rate of 155.6 for malignant neoplasms, which was the second leading cause, based on 16,637 deaths. Vascular lesions affecting the central nervous system, with 11,482 deaths, and accidents, with 5,471 deaths were third and fourth respectively in

rank. These four specific causes accounted for three out of every four deaths last year, about the same proportion as in 1965. Their rank order, which was determined by ranking all deaths according to the List of 64 Selected Causes of Death, has not changed in recent years.

Accidents continued to be the leading cause of death in each age group between 1-24 years, and it replaced heart disease as the leading cause in the age group 25-44. Violent deaths — accidents, suicides, and homicides claimed nearly 7 out of 10 lives in the age group 15-24, and 3 out of 10 in the 25-44 age group. In both these age groups combined, violent deaths rose nearly 13 per cent from 1965 to 1966.

No significant changes occurred among leading causes of death with respect to sex. Accidents were a major cause of death for both males and females at all ages, but more particularly the younger age groups. Diabetes mellitus appeared in the five leading causes for females aged 45-64 and 65 and over, but among males, corresponding causes were cirrhosis of the liver and influenza and pneumonia.

Marriages and Divorces

A final total of 80,794 marriages were performed in Ohio during 1966, which was an increase of 1,812 over 1965. The marriage rate was 7.6 per 1,000 population, slightly higher than 1965.

First marriages accounted for approximately 68 per cent of all marriages for both bride and groom. A total of 61,301 (about 76 per cent) were married for the first time, while for brides this figure was 61,025, again about 76 per cent.

Both the bride and groom were residents of Ohio in 74,085 or 91.7 per cent of all marriages, while grooms were residents in 74,196 — 91.8 per cent — of the marriages, and brides were Ohio residents in 78,982, or 97.8 of all marriages.

The most popular month for marriages once again was June, with 10,024 or 12 per cent of the total. August was favored with 8,534, and July totaled 8,514, with each month having about 10 per cent of the total. These three months, June through August, accounted for over 33 per cent of all marriages performed.

More grooms (7,924) married at age 21 than at any other, but close behind were those aged 22, with 7,702. For brides, the most frequent age at marriage was 19, with a total of 11,077. Brides aged 18 totaled 9,396.

In Ohio, there were 27,914 divorces and annulments reported for the year 1966, an increase of 8.3 per cent over 1965. The divorce rate of 2.6 per 1,000 population was up from 2.4 in both 1964 and 1965.

"Gross neglect of duty" and "gross neglect and extreme cruelty" were reported as legal grounds for the majority of divorces. About 75 per cent, or



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20,944, of all divorce and annulment decrees were granted to the wife.

Of the 27,914 marriages terminated, 10,976 had no minor children. The balance, however, which represent over 60 per cent of all terminations, involved one or more such children.

A total of 3,847 marriages, or nearly 14 per cent of the total, were terminated within two years of the marriage date. On the other hand, nearly as many (3,578) occurred 20 years or more after marriage.

Columbus Institute Grant Promotes Artificial Heart Research

Battelle Memorial Institute in Columbus has been awarded a grant of \$63,600 by the Public Health Service's National Heart Institute in support of research on devices in the artificial heart field. The grant is for one of six contracts awarded to support studies leading to development of materials compatible with blood for use in construction of circulatory assist devices.

It was announced that the National Heart Institute has awarded 25 new contracts and extended 16 others in support of research basic to the development of circulatory assist devices and artificial hearts. Total amount involved in the latest contracts is \$2,784,687, the latest in a series awarded by the Artificial Heart Branch of NHI Artificial Heart-Myocardial Infarction Program.

Since June of 1964, the Artificial Heart Branch has let 73 contracts totaling approximately \$12 million.

State Medical Board Issues Licenses To 318 Doctors of Medicine

Results of the examinations conducted by the State Medical Board of Ohio June 19-21 were considered by the Board at its meeting on July 31, and announced by Dr. W. Thomas Washam, Executive Secretary.

Certificates to practice medicine and surgery were awarded to 318 graduates of Schools of Medicine. Certificates to practice osteopathic medicine and surgery were awarded to 58 graduates of osteopathic schools; also 27 chiropodists, or podiatrists, were authorized to receive certificates for practice in their fields.

In the limited practice branches, six were awarded certificates to practice mechanotherapy, 19 to practice chiropractic, and three to practice massage.

Two persons tied for highest grade in the examinations for doctors of medicine. They are Luther E. Lindner, Toledo, and Robert Meade Christian, Jr., Richmond, Va., both graduates of Western Reserve University School of Medicine, and both with an average of 91 per cent. Third high of 89 per cent was made by Geoffrey P. Herzig, Cincinnati, another graduate of Western Reserve.

Sixth District Postgraduate Day Scheduled in Warren, Oct. 25

The Sixth Councilor District Postgraduate Day will be held this fall at the Packard Music Hall in Warren, with the Trumbull County Medical Society as host organization. All interested physicians are invited to attend. The date is Wednesday, October 25.

An excellent scientific program has been arranged and details as to topics and speakers will be published in the October issue of *The Journal*. Theme of the program will be "Controversies in Medicine."

Dr. George A. Sudimack, of Warren, is program chairman, the third time he has arranged the program for the annual event. Contacts in regard to the program may be made with Dr. Sudimack or with the Trumbull County Medical Society, 280 North Park Avenue, Warren 44481.

Registration opens at 8:00 A. M., with a CPC at 8:30 and the main features of the program beginning at 9:00 o'clock. Coffee will be served for early arrivals. A nominal fee covers registration and luncheon. The program concludes at 5:00 P. M.

Data on Cost of Alcoholism in Overall National Economy

The cost of alcoholism is not adequately reflected by morbidity and mortality statistics. The National Council on Alcoholism estimates an annual loss to industry of over \$2 billion, resulting from absenteeism, lowered productivity, and accidents associated with alcoholism. Moreover, there is an immeasurable toll of disrupted family life.

Over the past thirty years there has been a considerable effort to deal with alcoholism by interested physicians, Alcoholics Anonymous, the National Council on Alcoholism, and industrial programs. Recently the Department of Health, Education, and Welfare undertook a major program of research, education, and professional training to combat alcoholism.

Its objectives are to make available to alcoholics the best treatment and rehabilitation services, to improve techniques of treatment, and to find effective ways of preventing the disorder.

A national center for the prevention and control of alcoholism is being established within the National Institute of Mental Health at Bethesda, Maryland. An 18-member national advisory committee on alcoholism is being set up to include representatives of medicine, social work, labor, industry, vocational rehabilitation, education, law, and civic organizations concerned with alcoholism. It is expected that these efforts will spur new and better approaches to combating the menace of alcoholism. — Excerpts from Metropolitan Life Insurance Company Statistical Bulletin.

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Ad Astra

Paul A. Davis, M. D., Akron, outstanding practitioner in the field of public health and industrial medicine, Past President of the Ohio State Medical Association, active in medical organizational work on the county, state, and national levels, died on August 4 at the age of 77.

Dr. Davis was named President-Elect of the Ohio State Medical Association in 1952 after serving six years as Councilor of the Sixth District, and began his year of service as President in 1953. He was



Dr. Davis

active in the organization of the American Academy of General Practice and served as that group's first president, and for many years as a member of its Board of Directors. He also represented the AAGP in the House of Delegates of the American Medical Association.

A native of Chillicothe, Dr. Davis received his college training at Ohio State University and was awarded the M. D. degree from the College of Medicine in 1916. As part of his residency training, he studied industrial medicine, surgery and toxicology at Goodyear Hospital and the University of Chicago. After serving in the Medical Corps of the Air Force during World War I, he returned to Goodyear Hospital in Akron where he was named industrial toxicologist and surgeon. His private practice for many years was in industrial consultant field and included medical direction for several companies in the Akron area.

Dr. Davis was a past president of the Summit County Medical Society and a former member of the Council of that organization. He served for many years as chairman of the Section on General Practice of the AMA. Also he represented the Section on Industrial and Preventive Medicine and Public Health to the AMA Committee on Scientific Exhibits. For a time he held an appointment by the President of the United States on the National Medical Committee on Rehabilitation of the Physically Handicapped.

Among professional affiliations, he was a member of the American Rheumatism Association, the Industrial Medical Association, and the American College of Preventive Medicine, in addition to the AMA and AAGP. His published articles in the

field of industrial medicine and toxicology were numerous.

He was a 32nd Degree Mason and held memberships in many other fraternal and civic organizations. Mrs. Davis who survives was a former president of the Woman's Auxiliary to the Ohio State Medical Association.

Charles Hodge Bailey, M. D., East Liverpool; University of Michigan Medical School, 1908; aged 85; died July 21; member of the Ohio State Medical Association and the American Medical Association; diplomate of the American Board of Surgery. Dr. Bailey's practice in the East Liverpool area extended from 1910 to his retirement in 1953. He was a veteran of World War I and among affiliations was a member of the American Legion and the VFW. Active in community affairs, he was former director of the Chamber of Commerce, was a member of the Elks Lodge, several Masonic bodies, and the Presbyterian Church. Survivors include his widow and a sister.

William Vollie Barton, M. D., St. Marys; Emory University School of Medicine, 1930; aged 69; died July 4; member of the Ohio State Medical Association, the American Medical Association, and the American Society of Abdominal Surgeons. A native of Georgia where his father and grandfather were physicians, Dr. Barton moved to Ohio in about 1933 and to St. Marys in 1935. He was on the Board of Governors of the Joint Township Memorial Hospital, was active in the Chamber of Commerce, and many other community activities, as well as several Masonic bodies. Three sisters survive.

Paul Rannells Bauman, M. D., Columbus; University of Cincinnati College of Medicine, 1924; aged 68; died July 11; member of the Ohio State Medical Association and the American Medical Association. Dr. Bauman's practice in Columbus extended over a period of some 40 years. Among affiliations he was a member of the Masonic Lodge. His widow and a son survive.

William E. Burkhart, M. D., Columbus; Ohio State University College of Medicine, 1945; aged 46; died July 14; member of the Ohio State Medical Association, the American Medical Association, American Society of Internal Medicine; Fellow of the American College of Physicians; diplomate of

the American Board of Internal Medicine. A practicing physician in Columbus, specializing in internal medicine, Dr. Burkhart was on the faculty of Ohio State University College of Medicine. Surviving are his widow, a son, his mother, and a sister. Dr. Burkhart was a member of the First Community Church where his late father was pastor for many years.

Roy Edmund Bushong, M. D., Lima; Ohio State University College of Medicine, 1911; aged 81; died July 19; member of the Ohio State Medical Association, the American Medical Association, and the American Psychiatric Association. A pioneer leader in Ohio's mental hygiene system, Dr. Bushong was former state commisisoner of mental hygiene and served a long tour at Lima State Hospital. Upon his retirement in 1957 as superintendent of Lima State Hospital, he served four years as director of training and research at the Toledo State Hospital. He was a member of the United Church of Christ, the Rotary Club, the T & T Club and the Elks Lodge. Surviving are his widow and a daughter.

Clyde Marvin Fitch, M. D., Portsmouth; Johns Hopkins University School of Medicine, 1921; aged 72; died April 9; member of the Ohio State Medical Association, the American Medical Association, and the American Academy of General Prac-

tice. Long a resident of Portsmouth, Dr. Fitch returned there in 1925 to practice in association with his father, the late Dr. James W. Fitch. Dr. Clyde Fitch, in addition to his private practice, was active in community affairs. He was past president of the Scioto County Medical Society, devoted much time to promotion of local hospital facilities; was a member of the American Legion, the Methodist Church, and the Lions Club. His widow and a sister survive.

Charles L. Fox, M. D., Fremont; Ohio State University College of Medicine, 1917; aged 83; died July 3; member of the Ohio State Medical Association and the American Medical Association. A practitioner of long standing in Sandusky County, Dr. Fox practiced for a short time at Lindsey before he moved to Fremont in 1927. He was a member of the Lutheran Church and the Elks Lodge, and was active in the YMCA and other community organizations. Dr. Robert C. Fox, of Green Springs is a son. Also surviving are his widow, another son, a brother, and two sisters.

Paul Edwin Foy, M. D., Troy; St. Louis University School of Medicine, 1936; aged 56; died July 1; member of the Ohio State Medical Association, the American Medical Association, and the American Academy of General Practice. A practitioner in the Troy area for some 30 years, Dr. Foy was a



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veteran of World War II, having served overseas in the Medical Corps. He was a member of the Catholic Church, the Knights of Columbus, and the Knights of St. John. Among survivors are his widow, a son, a daughter, his parents, and a brother.

Isidore H. Fuhs, M.D., Canton; Western Reserve University School of Medicine, 1907; aged 85; died July 10; member of the Ohio State Medical Association and the American Medical Association. Formerly a practitioner in the field of internal medicine, Dr. Fuhs from 1921 to 1947 devoted his full time to pathology, being associated with Aultman Hospital. His widow survives.

Cullen W. Irish, M.D., Los Angeles, Calif.; Ohio State University College of Medicine, 1915; aged 77; died July 23. Dr. Irish practiced in Barberton from about 1918 to 1928. His widow, a son, and two brothers survive.

William McDowell Johnston, M.D., Akron; Jefferson Medical College of Philadelphia, 1907; aged 86; died February 5; member of the Ohio State Medical Association. A practitioner of long standing in Akron, Dr. Johnston specialized in surgery.

Howard J. Luxan, M.D., Montpelier; Chicago College of Medicine and Surgery, 1916; aged 72; died June 30; former member of the Ohio State Medical Association. A former resident of Montpelier, Dr. Luxan returned there to practice in 1922. His total professional career covered more than a half century. He was former Williams County health commissioner and former county coroner. Among affiliations, he was a member of the Rotary Club and the Fraternal Order of Eagles. Surviving are his widow, a son, a daughter, a brother and a sister.

Thomas W. Mahoney, Sr., M.D., Toledo; University of Cincinnati College of Medicine, 1913; aged 79; died July 9. A career health officer, Dr. Mahoney served in health commission posts from

about 1918 to 1959. He was for many years Lucas County health commissioner, and before his retirement in 1959 was assigned to the Northwestern Ohio area for the Ohio Department of Health. He was a veteran of World War I. Among survivors are two daughters and a son, Dr. Thomas W. Mahoney, Jr., of Toledo; also a sister.

George Monroe, M.D., Sandusky; University of Michigan Homeopathic Medical School, 1908; aged 83; died July 17. A resident for many years in Columbus, Dr. Monroe was living in retirement in the Sandusky area. She was the widow of the late Professor Robert Monroe. Dr. Emmett P. Monroe, of Silver Lake, is a son. Other survivors include another son and two daughters.

Michael Paul Motto, M.D., Cleveland Heights; Cleveland-Pulte Medical College, 1913; aged 80; died July 5; member of the Ohio State Medical Association, the American Medical Association, and the American Academy of Ophthalmology and Otolaryngology; Fellow of the American College of Surgeons; diplomate of the American Board of Ophthalmology. An ophthalmologist for many years in Cleveland, Dr. Motto was former assistant professor of ophthalmology at Western Reserve University School of Medicine. Active in organization work, he was a past president of the Academy of Medicine of Cleveland. Among survivors are his widow and a daughter.

John Milton Painter, M.D., Kent; Western Reserve University School of Medicine, 1933; aged 60; died July 4; member of the Ohio State Medical Association, the American Medical Association, and the American College of Allergists. A practitioner in the Kent area since 1935, Dr. Painter was active in community affairs. He was a member of the United Church of Christ, a member of the Rotary Club, and was active in the promotion and improvement of the local hospital. Among survivors are

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two daughters and a son by a previous marriage, his widow and his step-children.

Evelyn M. Partymiller, M. D., Cincinnati; University of Cincinnati College of Medicine, 1931; aged 61; died June 25; member of the Ohio State Medical Association and the American Academy of General Practice. A practitioner for many years in the Mt. Auburn area of Cincinnati, Dr. Partymiller was on the staffs of Christ Hospital, Longview Hospital and others. She is survived by her husband, Bernal R. Woodward.

Joseph Alexander Ralston, M. D., Warren; Jefferson Medical College of Philadelphia, 1937; aged 58; died April 9; member of the Ohio State Medical Association, the American Medical Association, and the American Academy of General Practice. A general practitioner of long standing in the Warren area, Dr. Ralston was a veteran of World War II, having served in the Air Force Medical Corps. His widow survives.

Kenneth E. Reighard, M. D., Alliance; Ohio State University College of Medicine, 1925; aged 73; died July 17; member of the Ohio State Medical Association and the American Medical Association. A general practitioner of long standing in Alliance, Dr. Reighard was living in retirement in recent years. He was a member of the Lutheran Church, the American Legion, Rotary Club, and several Masonic bodies. Survivors include his widow, a son, a daughter, and a sister.

Louis Rubin, M. D., Cleveland; University of Maryland School of Medicine, 1910; aged 78; died July 2; former member of the Ohio State Medical Association and the American Medical Association. After a few years of practice in his native Baltimore, Dr. Rubin moved to Cleveland in 1917. He was honored in 1960 for 50 years of service in the

profession. In recent years he was in semi-retirement. Surviving are his widow, a daughter, and three brothers.

Albert I. Sherman, M. D., Columbus; Ohio Medical University, Columbus, 1902; aged 91; died July 19; former member of the Ohio State Medical Association. A former resident of Maxville, Dr. Sherman practiced for many years in Perry County and in the adjoining areas of Hocking County. He was a member of the Congregational Church and the Masonic Lodge. Two daughters survive.

Clayton Sidney Smith, M. D., Columbus; Northwestern University Medical School, 1920; aged 80; died July 10; member of the Ohio State Medical Association and the American Medical Association. In addition to his medical degree, Dr. Smith also held a Ph.D. degree from Columbia University. Until his retirement in 1957, he was departmental chairman at the Ohio State University College of Medicine where he taught physiological chemistry, pharmacology, and materia medica. He held memberships in several professional organizations, was a member of the Masonic Lodge, the Optimist Club, and the Congregational Church. Surviving are his widow, a son, and a sister.

Donald H. Volzer, Jr., M. D., Canton; Ohio State University College of Medicine, 1953; aged 41; died June 20; member of the Ohio State Medical Association, and the American Medical Association. A life resident of Canton, Dr. Volzer returned there to practice after his medical training. He was a veteran of World War II, during which he served in the Navy, and was a member of the Catholic Church. His parents and a sister survive.

Henry Elmer Wedig, Sr., M. D., Cincinnati; Eclectic Medical College, Cincinnati, 1928; aged 64;



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died July 18; member of the Ohio State Medical Association, the American Medical Association, and the American Academy of General Practice. Dr. Wedig practiced for some 40 years in the Newtown area of Greater Cincinnati. Among survivors are his widow and a son, Dr. Henry E. Wedig, Jr., who was associated with his father in practice; also four brothers.

Lloyd Frederick Zacharias, M.D., Cincinnati; Eclectic Medical College, Cincinnati, 1936; aged 57; died June 26; member of the Ohio State Medical Association and former member of the American Medical Association; diplomate of the American Board of Obstetrics and Gynecology. A practitioner in Cincinnati, Dr. Zacharias specialized in obstetrics and gynecology. His widow survives.

Shriners Join National Blood Bank Reserve Program

A joint announcement was made recently by the Central Office for Shriners Hospitals and the American Association of Blood Banks in Chicago, on the establishment of a National Shrine Hospitals Blood Reserve Program.

Purpose of the plan is to assist the nation's non-profit blood banks with their responsibility of supplying blood and plasma wherever and whenever needed.

The plan worked out in cooperation with the American Association of Blood Banks will be implemented through its National Clearinghouse Program which handles reciprocal exchanges of blood and blood credits for over 750 participating blood banks and drawing stations throughout the United States.

It is estimated that the blood requirements for the 16 Shrine orthopedic hospitals and three burn centers (one in Cincinnati), amount to approximately 3600 units annually, and this need is expected to increase to 7500 units when the burn institutes are in full operation.

AMA Sponsors Disaster Care Program in Miami Beach

The application of the concepts of daily emergency medical care to the disaster situation will be analyzed at the First Biennial Symposium on the Management of Trauma and Disaster Medical Problems, in Miami Beach, Friday and Saturday, November 10 and 11, 1967.

Sponsored by the American Medical Association's Committee on Disaster Medical Care of the Council on National Security, the two-day symposium will be held at the Carillon Hotel.

For additional information write: Committee on Disaster Medical Care, American Medical Association, 535 North Dearborn, Chicago, Illinois 60610.

PHS Urban-Industrial Health Office Now in Cincinnati

The National Center for Urban and Industrial Health, an arm of the Public Health Service charged with eliminating health hazards associated with urban living, has established permanent headquarters in Cincinnati.

The Center, one of the major operating units of the Service's Bureau of Disease Prevention and Environmental Control, was created in January as part of a general reorganization of the Public Health Service.

Establishment of the Center in Cincinnati brings together in one location numerous Public Health Service programs involving research, training, and technical and financial assistance in such environmental health fields as solid waste management, prevention of occupational illness, control of injury hazards, milk and food sanitation, health implications of the use of water and sea resources, and environmental engineering.

The move of the National Center from temporary headquarters in the Washington area to rented facilities in Cincinnati is the first step in a program that will eventually find the Center housed in permanent facilities on the campus of the University of Cincinnati.

The University is now developing a major environmental health program under a grant from the Public Health Service. It has made available a tract of land close to the main University campus on which will be built a facility to house the National Center for Urban and Industrial Health. Completion of the building is still several years in the future.

Much of the technical staff and programs now a part of the Center have been located in Cincinnati for many years. The move to Cincinnati which was completed on July 31, shifted to Ohio the Office of the Center director, the Center's grants program, and the top administrative staff for each of the operating programs, with the exception of Arctic Health.

Director of the Center is Jerome Svore. Deputy director is Paul W. Kabler, M.D., the associate director is Murray Brown, M.D., and the assistant director is Howard Kusnetz.

At midyear 1967, the Veterans Administration had guaranteed or insured 6,690,744 home loans which totaled more than \$66 billion, and had disbursed 274,127 direct loans amounting to \$2.5 billion in rural areas where ordinary lending facilities were not available to veterans.

The number of veterans in civil life increased by 271,000 during the past year to a total of 25,846,000, the Veterans Administration reports.

Woman's Auxiliary Highlights...

By MRS. S. L. MELTZER, Chairman, Publicity Committee

2442 Dorman Drive, Portsmouth 45662

ALL ROADS are leading to Canton! . . . to Fall Conference . . . and to a two-day session of practical help, down-to-earth planning . . . and even some fun . . . The WHEN of it? September 28 and 29. The WHERE of it? Downtowner Motel in lovely Canton (it's in the heart of town with provision for ample parking space).

The WHO of it? First and foremost of course, our President, Mrs. Paul Sauvageot, and our President-Elect, Mrs. Malachi W. Sloan, II (Mrs. Sloan is in direct charge of Fall Conference); a close second are two hard-working, enthusiastic and dedicated Stark County auxiliary members: Mrs. Charles Houck and Mrs. Clarence V. Smith who, believe it or not, have been working on plans for Fall Conference since May (conferences, like conventions, demand a lot of long-range doing); and third in line, close behind, are all the members of your State Auxiliary Board, anxious to land two helping hands!

The WHY of it? To give assistance and inspiration to every county auxiliary—to try to give full meaning to each auxiliary's reason-for-being, whether the auxiliary be big or small. The HOW of it? Through the medium of its theme—"Let's Tell Our Story"; public relations is at the heart of this year's programming (those of you lucky enough to hear Ludel Sauvageot's inaugural remarks will recall how she stressed good public relations and the need to tailor Auxiliary programs to the situations of the individual community).

To the best of my knowledge, this is the first time that northeastern city of Canton has played hostess to a Fall Conference. It behooves every auxiliary to be represented by at least two of its members. For its own sake, primarily, of course. But also to show Stark County that the rest of us in

the state appreciate their tremendous efforts on our behalf. (You have no idea what "playing hostess" in this instance really entails!) Well—maybe some of you do. At any rate, prove it!

The "Line-Up"

Registration will be between 10:30 A. M. and 12 NOON on Thursday, September 28, in the lobby of the motel. (Incidentally room reservations are to be made directly with the Downtowner Motel). There will be these vital workshops: On Leadership Development, on Membership, on Community Service. There will be outstanding exhibits on International Health, Credits and Awards, AMA-ERF. There will be small, informal group meetings with the Treasurer, and those two "allies"—Publicity chairman and Auxiliary News editor.

There will be special programs on Safety, Legislation, and Community Programs in Action. There will be a luncheon on Thursday, September 28, at which Mr. Robert Wagner, Public Relations Director of Timken Roller Bearing Company, will be the guest speaker. Since public relations is at the heart of this year's auxiliary program, it seems a "natural" to have someone like Mr. Wagner talk to us. His approach will be slanted toward education. This should certainly be of special interest to us as we begin to place more and more emphasis on Health Education. There will be one other "outsider" assisting with the Fall Conference program: Mrs. Norman L. Moore, a member of the Board of Trustees at Aultman Hospital (Canton) who will be working with our President, Ludel Sauvageot, on Leadership Development.

Weather permitting on that first day of Conference, there will be a Poolside Party—a time for fun and relaxation and getting to know each other. There

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will be a Conference dinner, at which Mrs. C. R. Crawley and her Safety Committee will provide some unusual entertainment. We shall have two very special guests: Mrs. John Dickie, National Regional Vice-President, and Mrs. Herbert F. Van Epps, National Regional AMA-ERF chairman.

There will be some Breakfast Sessions on Friday morning to warm things up! And then from 9:45 to 11:30 A. M., there will be sessions first on Legislation (a new film will be presented) and there will be audience participation. Mrs. Jay L. Ankeney of Cuyahoga County will highlight her auxiliary's highly successful program on Family Life Education. Members of Lucas County will present a skit spotlighting their efforts in a program of community service.

And Mrs. Paul Jones of Zanesville and her county auxiliary (Caroline this year is state Credits and Awards chairman) will be providing some beautiful and unusual table arrangements. I am told that there have been some notable prize winners from this area.

The September Auxiliary News will contain detailed information on Fall Conference. I'm only hitting the high spots. One last word—to members-at-large: PLEASE come. Your state officers want very much to greet you, see you, know you, help you.

The State Auxiliary says LET'S TELL OUR STORY! Will you please come to Fall Conference to hear it—and then pass the story along? We'll be looking for you.

Around the State

My apologies to those of you who sent in publicity items as far back as May! Because of the long, detailed stories on our Ohio State convention and that of the AMA, I have not been able to include local items in recent issues. Please don't be discouraged! I'm going to try to work some local items into this column—right now!

The Columbiana Auxiliary celebrated a very special day back on May 23rd—its Silver Anniversary. Some 80 women attended the beautiful "Rose Luncheon" (it was also a Guest Day) at the Lape Hotel in Salem. The welcome was given by Mrs. R. J. Bonistalli, retiring president, who also gave the invocation. Mrs. Wade Bacon presented bracelet charms as tokens of appreciation to those who organized the group 25 years ago: Mrs. C. H. Bailey, Mrs. R. C. Costello, Mrs. John A. Fraser, Mrs. M. M. Gottlieb, Mrs. William J. Horger and Mrs. M. D. McCutcheon. There was special recognition accorded the ten charter members present. Recognition was given Karen Echard, a student nurse, who has received a loan from the auxiliary through its medical careers' fund.

Mrs. Charles Gerace, a past president, installed these new 1967-68 officers: President, Mrs. K. S. Ulicny; president-elect, Mrs. Stephen G. Sinclair; vice-president, Mrs. Lee Bookwalter; secretary, Mrs. W. F. Stevenson; treasurer, Mrs. A. P. Falkenstein.

Mrs. H. E. Muller, Rose Luncheon chairman, introduced the program speaker, Mrs. Dhu Clemenson, a florist from Akron, who reviewed experiences of the business while she demonstrated the making of corsages. She presented Mrs. Muller with a candlestick centerpiece arrangement. The corsages were given as door prizes. Table centerpieces featured topiary rose trees adorned with pink and white net and pink ribbons. Miniature spring bonnets held the round program booklets. Those serving on this special events committee included: Mrs. Muller, chairman; Mrs. V. C. Hart, Mrs. A. P. Falkenstein, Mrs. R. J. McConnor, Mrs. L. Pritchard and Mrs. W. F. Stevenson.

Cuyahoga County's first meeting of the new Auxiliary year will be on September 22 at the University Club. Eugenia Thornton, well-known educational-



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television personality, will give a book review. Members are urged to bring along potential new members. Mrs. Henry A. Crawford and Mrs. Reuben Gould served as hostesses at the Orientation Program for New Foreign Medical Graduates held on July 26 at the Academy of Medicine. Assisting at the refreshment table were Mrs. William Mast and Mrs. Elden C. Weckesser.

Half-Page Spread

Hamilton County auxiliary has done it again! On July 20, the *Cincinnati Enquirer* devoted a half-page spread to "Doctors' Wives Plan Projects, Programs." There were three large photographs: the first having to do with "Comparing Ideas on Programs for the Year"; the second "Checking the Files to Correct Addresses and Phone Numbers of the 630 Medical Auxiliary Members"; and the third a picture of Mrs. Joseph E. Ghory, president, welcoming board members into her home for a preview of the 1967-68 season. "There may be a few less readers in mid-summer," comments Mrs. Robert E. Krone, publicity chairman, "but we find the club editors are looking for material and thus willing to give good coverage." The *Enquirer* certainly gave remarkably detailed coverage to Hamilton's full schedule of projects and plans.

On May 9, the *Cincinnati Post and Times-Star* came up with some pretty generous coverage itself on a feature story concerning Hamilton County's new president, Mrs. Joseph E. Ghory. It not only told the story of Mrs. Ghory but it told the auxiliary story—again in remarkable detail. This is the kind of publicity—the kind Hamilton County gets—that every county auxiliary hopes for but seldom is lucky enough to capture! And while we're looking back to the merry month of May, mention should be made of an interesting luncheon sponsored by these doctors' wives at which David Barrie highlighted his talk on contemporary drama with scenes from plays of the Cincinnati summer season. The luncheon was served on the terrace of Our Lady of Cincinnati College overlooking the Ohio River.

New officers were installed by Mrs. Paul Hahn, District Seven director, when the Tuscarawas County group met for its June meeting at Reeves Motor Inn. Installed were Mrs. Efrain Padro as president; Mrs. L. L. Appel as president-elect; Mrs. E. L. Miller as vice-president; Mrs. Robert Hastedt as secretary. The May meeting of the Tuscarawas group was also held at Reeves Motor Inn. A short business meeting conducted by the president, Mrs. E. L. Miller, followed the luncheon. Changes in the Constitution were discussed by Mrs. Herbert F. Van Epps. The social hour featured bridge and other games. The prizes were flower baskets which had centered the luncheon tables.

The Trumbull Auxiliary held its Installation Tea at the home of Dr. and Mrs. M. E. Sorrell. Mrs.

J. Phillips was inducted as president; Mrs. C. M. Venetta, president-elect; Mrs. J. R. Willoughby, vice-president; Mrs. A. A. Guiducci, recording secretary; Mrs. D. Chickering, corresponding secretary; Mrs. A. L. Williamson, treasurer.

That Publicity

The Auxiliary year is about to get under way in a burst of glory. Yours may be the biggest group in the state, or it may be the smallest, but you all have a story to tell! You may be engaged in a host of projects, or you may limit your projects to a certain few. It doesn't matter to this column how much you do but rather WHAT you do! There are so many groups from whom I do not hear during the year. I may meet a member of one of these groups at convention or conference time who will tell me, "We didn't think you'd be interested in our small accomplishments." BUT I AM INTERESTED! AND THE READERS OF THIS COLUMN ARE INTERESTED!

Occasionally, as happened recently because of two important conventions, your reporter has had to omit local items. But believe me, that is the exception rather than the rule. Usually if there is a paucity of local news coverage, it is because I'm not kept informed. May I please hope for your strong cooperation this 1967-68 Auxiliary year?

Important Words

From your President, Mrs. Paul Sauvageot: "The year has started out at a good pace but we must increase the tempo if we are to accomplish as much as we'd like."

Small Arabian State Publishes Its Own Medical Journal

The international flavor of medicine is reflected in a note from the editor and a copy of Volume 1, No. 1 of *The Journal of the Kuwait Medical Association*. This publication from the region on the Arabian Gulf is printed mostly in English.

The University of Kuwait was opened in November, 1966, with three faculties, in Science, Art, and Education. Need is expressed for a medical school. The number of doctors in Kuwait is about 725, only 21 of whom are Kuwaities.

The president of the association, in introducing the new publication, stated: "Our Association, with this new endeavor, is fulfilling its promise to participate actively in contributing to the field of Medicine."

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BUTLER—Brady Randolph, President, 128 North Front Street, Hamilton 45011; Mr. Charles G. Greig, Executive Secretary, 110 North Third Street, Hamilton 45011. 3rd Wednesday monthly.

CLERMONT—Noco Capurro, President, 481 Craig Road, Cincinnati 45244; Albert W. Van Sickle, Secretary, Box 365, Batavia 45103. 3rd Wednesday monthly except July, August and December.

CLINTON—H. Richard Bath, President, 290 West Main Street, Wilmington 45177; Mary R. Boyd, Secretary, Box 629, Wilmington 45177. 4th Tuesday monthly.

HAMILTON—Stanley D. Simon, M.D., President, 320 Broadway, Cincinnati 45202. Mr. Edward F. Willenborg, Executive Secretary, 320 Broadway, Cincinnati 45202. 3rd Tuesday monthly.

HIGHLAND—Thomas L. Jones, President, 528 South Street, Greenfield 45123; Glenn B. Doan, Secretary, 614 Jefferson Street, Greenfield 45123.

WARREN—George A. Rourke, President, 210 Mound Street, Lebanon 45036; Ray E. Simindinger, Secretary, 901 North Broadway Street, Lebanon 45036. 2nd Tuesday monthly.

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CLARK—H. B. Elliott, President, 25 West Harding Road, Springfield 45504; Mrs. Marion L. Wilcoxson, Executive Secretary, 616 Building, Room 131, 616 North Limestone Street, Springfield 45503. 3rd Tuesday monthly.

DARKE—E. Westhrook Browne, President, 330 West 4th Street, Greenville 45331; Giles Wolverton, Secretary, Darke County Department of Public Health, Court House, Greenville 45331. 3rd Tuesday monthly.

GREENE—Richard A. Falls, President, 1148 North Monroe Drive, Xenia 45385; Mrs. C. K. Elliott, Executive Secretary, 225 Pleasant Street, Xenia 45385. 2nd Thursday monthly, except July and August.

MIAMI—Robert L. Sutton, President, 423 West Main Street, Tipp City 45371; Robert J. Price, Secretary, 760 North West-edge Drive, Tipp City 45371. 1st Tuesday monthly.

MONTGOMERY—W. J. Lewis, President, 2567 Far Hills Avenue, Dayton 45419; Mr. Robert F. Freeman, Executive Secretary, 280 Fidelity Medical Building, Dayton 45402. 1st Friday monthly.

PREBLE—John D. Darrow, President, 228 North Barron Street, Eaton 45320; J. R. Williams, Secretary, 228 North Barron Street, Eaton 45320. December yearly.

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Third District

Councilor: Frederick T. Merchant, Marion 43302
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AUGLAIZE—R. S. Sobocinski, President, 7 South Blackhoof Street, Wapakoneta 45895; J. F. Bowling, Secretary, 319 West Spring, St. Marys 45885. 1st Thursday odd months, with exception of July.

CRAWFORD—Carl Ide, President, 140 Hill Street, Bucyrus 44820; G. Wesley Bowersock, 130 Hill Street, Bucyrus 44820. Meetings held on call.

HANCOCK—Joseph G. Barkey, President, 120 West Foulke Street, Findlay 45840; Carson P. Cochran, Secretary, 1725 South Main Street, Findlay 45840. 3rd Tuesday monthly.

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LOGAN—G. E. Munn, President, 120 East Sandusky Street, Bellefontaine 43311; J. Terebuh, Secretary, Colonial Arms Apt. 10, Bellefontaine 43311. 1st Friday monthly.

MARION—Richard W. Mills, President, 170 Fairfax Road, Marion 43302; Alice P. Fisher, Secretary, 1040 Delaware Avenue, Marion 43302. 1st Tuesday monthly.

MERCER—Cecil E. Pennington, President, 406 South Oak, Coldwater 45828; George H. McIlroy, Secretary, 123 East Fayette Street, Celina 45822. 3rd Thursday monthly.

SENECA—Lowell K. Good, President, 133 West North Street, Fostoria 44830; W. F. Yarris, Secretary, 301 Perry Street, Fostoria 44830. 3rd Tuesday every other month.

VAN WERT—Wilmer L. Iler, President, Medical Arts Building, Fox Road, Van Wert 45891; Fred E. Culler, Secretary, 938 South Washington Street, Van Wert 45891. 4th Friday monthly.

WYANDOT—Joseph J. Browne, Acting President and Secretary, 777 North Sandusky Street, Upper Sandusky 43351. 2nd Tuesday monthly.

Fourth District

Councilor: Robert N. Smith, Toledo 43606
3939 Monroe St.

DEFIANCE—George L. Boomer, President, 1075 East Second Street, Defiance 43512; Miss Lois Coffin, Executive Secretary, P. O. Box 386, Defiance 43512. 1st Saturday monthly.

FULTON—F. E. Elliott, President, 203 Beech Street, Wauseon 43567; R. L. Davis, Secretary, 137 South Fulton, Wauseon 43567. Quarterly, March, June, September, and December, 2nd Tuesday.

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LUCAS—George T. Booth, President, 1006 Secor Hotel, Toledo 43603; Mr. Robert W. Elwell, Executive Secretary, 3101 Collingwood Boulevard, Toledo 43610. Council meets on 3rd Tuesday of each month except July and August.

OTTAWA—V. Wm. Wagner, President, 122 East Perry, Port Clinton 43452; William Coon, Secretary, 120 East Perry, Port Clinton 43452. 2nd Thursday monthly.

PAULDING—D. P. Ward, President, Box 416, Oakwood 45873; Richard D. Stagg, Secretary, Laura and Merrin Streets, Payne, Ohio 45880. Meetings held at call of President.

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GEAUGA—C. K. Adrian, President, Medical Arts Building, 13221 Ravenna Road, Chardon 44024; Mrs. Martha Withrow, Executive Secretary, P. O. Box 249, Chardon 44024. 2nd Friday monthly.

LAKE—Wm. C. Downing, President, 150 Mentor Avenue, Painesville 44077; Mrs. Owen A. McLaren, Executive Secretary, 7408 Cadle Avenue, Mentor 44060. 4th Wednesday evening of January, March, May, September, and November, unless otherwise ordered by the Council.

Sixth District

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438 North Park Ave.

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SUMMIT—L. V. Phillips, President, 2106 Braewick Circle, Akron 44313; Mr. S. H. Mountcastle, Executive Secretary, 430 Grant Street, Akron 44311. 1st Tuesday monthly.

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625 North Fourth Street

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Councilor: James A. Quinn, Newark 43055
1320 W. Main Street

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PIKE—A. M. Shrader, President, 196 Emmitt Avenue, Waverly 45690; Janie Hwang, Secretary, 300 Cherry Street, Waverly 45690. 1st Tuesday monthly.

SCIOTO—Chester H. Allen, President, 1405 Offnere Street, Portsmouth 45662; Erich Spiro, Secretary, 1735 Waller Street, Portsmouth 45662. February, April, July, October, and December (may be changes).

VINTON—Richard E. Bullock, President, 203 South Market Street, McArthur 45651.

Tenth District

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1211 Dublin Rd.

DELAWARE—C. S. Hambrick, President, Box 265, Delaware 43015; Tennyson Williams, Secretary, Box 508, Delaware 43015. 3rd Tuesday monthly.

FAYETTE—J. H. Persinger, President, 225 East Market Street, Washington C. H. 43160; M. H. Roszmann, Secretary, 1005 Temple Street, Washington C. H. 43160. 2nd Friday, noon, monthly.

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MADISON—John Starr, President, 196 Elm Street, London 43140; Martin Markus, Secretary, High Street, London 43140.

MORROW—Lowell Murphy, President, 209 South Marion Street, Cardington 43315; David James Hickson, Secretary, 712 Baker Street, Mt. Gilead 43338. 1st Tuesday monthly, 6:30 P. M. dinner.

PICKAWAY—Edward L. Montgomery, President, 213 East Main Street, Circleville 43113; Carlos Alvarez, Secretary, 147 Pinckney Street, Circleville 43113. 1st Friday monthly, except July and August.

ROSS—Richard L. Counts, President, 56 East Second Street, Chillicothe 45601; Walter Kramer, Secretary, 39 West Main Street, Chillicothe 45601. 1st Thursday monthly.

UNION—Malcolm MacIvor, President, 110 North Court Street, Marysville 43040; May B. Zaugg, Secretary, 130 North Maple Street, Marysville 43040. 1st Tuesday February, April, October, December.

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1749 Cleveland Road

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HOLMES—Charles H. Hart, President, 109 South Clay Street, Millersburg 44654; William A. Powell, Secretary, 8 West Adams Street, Millersburg 44654. 3rd Thursday monthly at the Village Restaurant, Millersburg.

HURON—Richard L. Jackson, President, 388 E. Howard Street, Willard 44890; John Rosso, Secretary, 218 Myrtle Avenue, Willard 44890. 2nd Wednesday of February, April, June, August, and December.

LORAIN—Robert S. VanDevort, President, 230 Hamilton Avenue, Elyria 44035; Mrs. Gladys Davidson, Executive Secretary, 428 West Avenue, Elyria 44035. 2nd Tuesday monthly, except June, July, and August.

MEDINA—B. A. Kassel, President, 750 East Washington Street, Medina 44256; Mr. A. Dana Whipple, Executive Secretary, 320 East Liberty Street, Medina 44256. 3rd Thursday monthly.

RICHLAND—Wendell M. Bell, President, 480 Glessner Avenue, Mansfield 44903; Mrs. M. K. Leggett, Executive Secretary, Mansfield General Hospital, Mansfield 44903. 3rd Thursday monthly.

WAYNE—Lyle Moyer, President, Dalton 44618; R. J. Watkins, Secretary, 1736 Beall Avenue, Wooster 44691. 2nd Wednesday, alternate months.

Heart Group Joins Sportsmen In Overall Safety Program

The Ohio State Heart Association has joined with the Ohio Division of Wildlife, conservation clubs and sportsmen's organizations in a Hunter Safety program this year. The Heart Association will stress Heart Safety, while the sportsmen's groups will emphasize the rules of safety with firearms.

Importance of a physical before the hunting trip is one of the Heart Safety rules urged by the Heart group, because usually a sedentary worker is called upon for expenditures of energy far beyond his daily routine when he takes to the woods in search of game. His physician can advise him on his limitations.

"Every hunting season the newspapers headline hunters who die of heart attacks in the field," says Dr. George Morrice, Jr., M.D., President of the Ohio State Heart Association. "We want to do what we can to prevent these men from becoming a cardiac statistic."

OSU Library Retrieval System

The Ohio State University College of Medicine has concluded a contract with the U. S. Public Health Service's National Library of Medicine for initial support of \$50,585 for a computer-based MEDLARS (Medical Literature Analysis and Retrieval System) program.

According to Dr. Richard L. Meiling, Dean of the College of Medicine, the new MEDLARS facility will enable the college to serve as a resource for the State of Ohio for the vast amount of information in the health fields.

The growing volume of published scientific material creates an urgent need for more efficient retrieval of health information, he said.

All citations contained in *Index Medicus*, are presently stored on magnetic tapes. This list of citations (now numbering over 550,000) can be searched at the College of Medicine to provide bibliographies as requested by biomedical professionals in Ohio.

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Advertisers in *The Journal* are friends of the profession. By accepting their advertising we show confidence in them and in their services and products. They underwrite a large portion of the printing cost of *The Journal*, and help make it a quality publication. In return we place their messages on the desks of Ohio's physicians. Please familiarize yourself with their services and products, and let them know that you see their advertising in *The Journal*.

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Condition	Number of Publications	Number of Patients	Significant Improvement†
Contact Dermatitis	27	750	713
Eczematous Dermatitis	21	472	409
Seborrheic Dermatitis	18	442	426
Atopic Dermatitis	24	460	426
Psoriasis	36	1,699	1,510
Neurodermatitis	18	351	324
Total	144	4,174	3,808

*Complete bibliography on request.

†Expressed by the authors as excellent, very good, good, complete remission of inflammation, etc.

longed periods of time. Prolonged use of any antibiotic may result in overgrowth of nonsusceptible organisms; if this occurs, appropriate therapy should be instituted. When severe local infection or systemic infection exists, the use of systemic antibiotics should be considered, based on susceptibility testing. **SIDE EFFECTS:** Side effects are not ordinarily encountered with topically applied corticosteroids. As with all drugs, however, a few patients may react unfavorably to Synalar under certain conditions. The neomycin in Neo-Synalar Cream rarely produces allergic reactions.

REFERENCES: 1. Lerner, L. J., Bianchi, A., Turkheimer, A. R., Singer, F. M., and Borman, A.: Anti-inflammatory steroids: potency, duration and modification of activities. *Ann NY Acad Sci* 116:1071 (Aug. 27) 1964. 2. Idem: Comparison of anti-granuloma, thymolytic and glucocorticoid activities of anti-inflammatory steroids. *Proc Soc Exp Biol Med* 116:385 (June) 1964. 3. Ringler, A.: Activities of adrenocorticosteroids in experimental animals and man, in Dorfman, R. I.: *Methods of hormone research*, New York, Academic Press, 1964, vol. III, pp. 234-280. 4. Gubersky, V. R.: To be published.

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Academy of Orthopaedic Surgeons Offers Program in Cleveland

The Committee on Injuries of the American Academy of Orthopaedic Surgeons will sponsor a three-day postgraduate course on management of trauma and disease of the spine November 27-29, at Hollenden House, 610 Superior Avenue, N.E., Cleveland. Registration opens at 8:00 A.M. on Monday, November 27, with program feature at 8:50 A.M.

Invited to attend are general surgeons, orthopaedic surgeons, and general physicians. The course will be held in cooperation with Case Western Reserve University School of Medicine.

The faculty is composed of 18 members of the school's staff and guest lecturers. Three major symposia are scheduled: "Cervical Spine," "Dorsal and Lumbar Spines," and "Scoliosis." It is the Committee's second annual Cleveland postgraduate course on treatment of fractures and other injuries and the first to deal in depth with the spine.

Dr. George E. Spencer, Jr., associate professor of Orthopaedic Surgery at Case Western Reserve, is director of the course. His address is 2065 Adelbert Road.

Registration fee is \$100.00, which includes three luncheons. Residents and interns will be admitted for \$10.00 fee by letter from the Chief of Service at their hospital.


Mental Health Digest Published By Governmental Agency

Mental Health Digest is the title of a new publication of the National Institute of Mental Health. Termed a "national clearinghouse for mental health information," first issues are being published on an experimental basis and with distribution to professional personnel working in or concerned with the field of mental health.

Information about subscriptions will be distributed later.

On January 1, 1967, the National Institute of Mental Health became a Bureau of the U. S. Public Health Service. With this change the NIMH moved out of the National Institutes of Health. The change was part of a total reorganization of the Public Health Service. It also involved the transfer of other PHS components to the NIMH as well as extensive reorganization of the NIMH itself.

The Public Health Service is now made up of five Bureaus: Bureau of Health Services, Bureau of Health Manpower, Bureau of Disease Prevention and Environmental Control, National Institutes of Health, and the National Institute of Mental Health. Two other components—the National Library of Medicine and the National Center for Health Statistics—also report directly to the Office of the Surgeon General of the PHS.



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AMA Council Issues Statement On Professional Courtesy

Following is a Statement of Professional Courtesy adopted by the Judicial Council of the American Medical Association at its June 17 meeting and released with the expressed hope that it will serve as a guideline to members of the Association.

"The custom of professional courtesy embodies the ancient tradition of fraternalism among physicians in the art which they share, and their mutual concern to apply their learning for the benefit of one another as well as their patients. The Judicial Council reaffirms and endorses the principle of professional courtesy as a noble tradition that is adaptable to the changing scene of medical practice.

"Professional courtesy is not a rule of conduct that is to be enforced under threat of penalty of any kind. It is the individual responsibility of the physician to determine for himself and within his own conscience to whom and the extent to which he shall allow a discount from his usual and customary fees for the professional services he renders, and to whom he shall render such services without charge as professional courtesy.

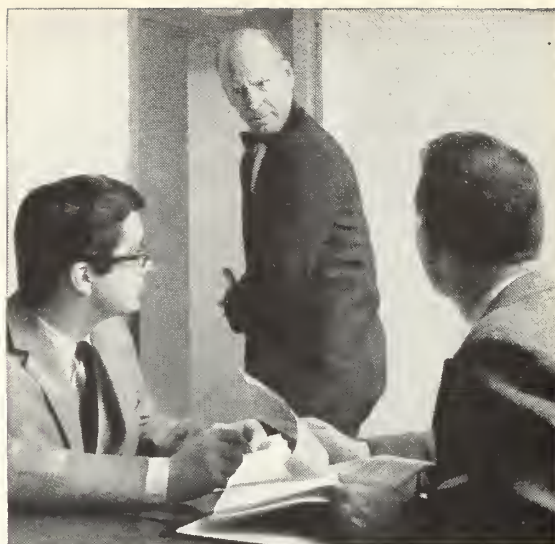
"The following guidelines are offered as suggestions to aid physicians in resolving questions related to professional courtesy.

"1. Where professional courtesy is offered by a physician but the recipient of services insists upon payment, the physician need not be embarrassed to accept a fee for his services.

"2. Professional courtesy is a tradition that applies solely to the relationship that exists among physicians. If a physician or his dependents have insurance providing benefits for medical or surgical care, a physician who renders such service may accept the insurance benefits without violating the traditional ethical practice of physicians caring for the medical needs of colleagues and their dependents without charge.

"3. In the situation where a physician is called upon to render services to other physicians or their immediate families with such frequency as to involve a significant proportion of his professional time, or in cases of long-term extended treatment, fees may be charged on an adjusted basis so as not to impose an unreasonable burden upon the physician rendering services.

"4. Professional courtesy should always be extended without qualification to the physician in financial hardship, and members of his immediate family who are dependent upon him."



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1. Carson, M., and Hart, L.: "New Perspectives on Nutritional Aspects of Modified Milk-Fat Formulas," Colloquium held under the auspices of The Pediatric Department, Western Reserve University School of Medicine at Cleveland, Ohio, Sept. 8, 1966. Data available on request.

2. Hegner, R.; *ibid.* 3. Nichols, M.; *ibid.* 4. McCann, M.L.; Teree, T., and Wallace, W.; *ibid.*

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Ohio Physician Leads Campaign Against Polio Outbreak

Dr. Robert A. Hingson, Cleveland, played a leading role in a campaign to curb a major outbreak of polio in Nicaragua. The story is related in the August 14 issue of *The AMA News*, under the heading, "Polio Epidemic Curbed by Medical Alliance."

In unique cooperative venture, the article states, the World Federation of Societies of Anesthesiologists (WFSA) and the American Society of Anesthesiologists (ASA) mobilized private medical and industrial resources to help control the outbreak.

Dr. Hingson, who is director of the Anesthesia Educational and Relief Foundation for the WFSA, while on the way to Honduras on another mission, received an emergency call from the Nicaraguan minister of health, and was the first American physician to arrive on the scene. He has been active in Central America in behalf of the Brother's Brother Foundation program.

WFSA and ASA sent three teams of anesthesiologists to Nicaragua, the first arriving on July 4, a few days after Dr. Hingson came on the scene. In response to 125 telegrams the Foundation sent out, 1.2 million doses of polio vaccine were delivered, plus

equipment and other supplies. The Federal Government sent an additional 500,000 doses of vaccine.

By July 24, the reported death toll was 52, with 395 children suffering paralysis, but the number of hospital admissions had dropped from some 25 a day to three or four. Dr. Hingson estimated that by late July, 95 per cent of the country's children had been immunized. Follow-up immunizations were scheduled to be given.

As *The AMA News* points out, this was "an unprecedented demonstration of the effectiveness of U. S. private enterprise and private medical groups in meeting an international health crisis (which) won the admiration of the U. S. Federal Government."

The Film Reference Guide for Medicine and Allied Sciences, 1967, is a guide to more than 2,600 film titles prepared by the Public Health Service Audiovisual Facility at Atlanta, Ga. It bears Catalog No. PS 2.60/10:967, and may be ordered from the Superintendent of Documents, Government Printing Office, Washington, D. C. 20402; \$2.25 per copy.

The Harvey Cushing Society, Inc., has a new name — The American Association of Neurological Surgeons.

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Dose: 1 to 5 tablets daily.

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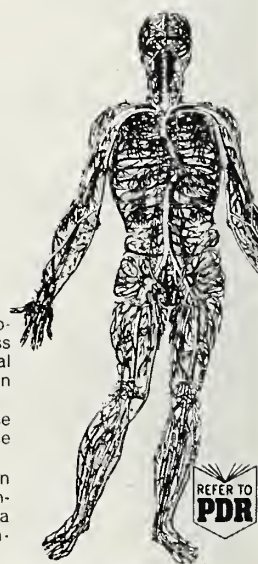
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The warm tingling flush which may follow each dose is one of the therapeutic effects that often produce psychologic benefits to the patient.

SIDE EFFECTS Flushing with heat and itching, in some cases followed by sweating, nausea and abdominal cramps. This reaction is usually transient. Nausea caused by high acidity can be relieved by non-absorbable antacid.

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Comments on Current Economic, Social And Professional Matters

AMA KEEPS SCHOOLS CURRENT ON HEALTH FIELD DEVELOPMENTS

How do school health educators keep up to date on the mass of information appearing in medical and science journals? How do they evaluate the mass of material that is being published in the name of science?

One of the ways is through a special publication issued by the American Medical Association. The AMA's Health Education Department in January 1961, inaugurated a service aimed at achieving just such an end. It started publishing and distributing the AMA Health Education Service for Schools and Colleges, a four-page bulletin, each issue of which contains a dozen or more concise articles highlighting important health news from medical journals and other science publications from throughout the world.

Currently, some 20,000 copies are distributed to schools and colleges each month, a fact attesting to its usefulness and one especially significant since only one copy normally is provided to each school.

This is another example of services performed by the AMA in behalf of the public as well as the medical profession, and another reason why the AMA deserves the support of every physician.

HIDDEN RESERVOIR MAY BE SOLUTION TO NURSE SHORTAGE

A hidden reservoir of nurse power may be the solution to the problem of nurse shortage in many communities, a recent article in *The Journal of the American Medical Association* points out. According to this article, an estimated 285,000 registered nurses throughout the country are inactive at this time.

The report prepared by the AMA Committee on Nursing indicates that many inactive nurses are eager to return to work, but hesitate because they do not possess the current knowledge, skills, and self-assurance required for nursing practice today. Some of the younger inactive nurses have small children, an additional barrier to full- or part-time work.

In recent action the AMA House of Delegates resolved that the American Medical Association take measures to insure calling attention of medical so-

cieties to the need for appropriate utilization of inactive nurses as well as retired physicians.

A good local program can retrain a nurse in four to six weeks, whereas it takes two to four years to train a new nurse to take over the same responsibilities. Groups in communities where such programs have not been undertaken would do well to contact personnel of the Committee on Nursing at the AMA headquarters in Chicago for detailed recommendations.

Bringing into activity even a small percentage of hidden nursing talent in the community may do much to alleviate current shortages.

WORLD MEDICAL ASSOCIATION, A MEANS TO A NOBLE END

"Every man owes some of his time to the up-building of the profession to which he belongs," according to a well-known quote from Theodore Roosevelt.

Many physicians may wish to consider this maxim in the light of membership and participation in the World Medical Association, an organization dedicated to promoting understanding among the doctors of the world.

Now in its 20th year, WMA is a federation of the most representative national medical associations in 60 nations. These member associations represent more than 700,000 physicians, a substantial majority of all the scientifically trained physicians in the world.

The World Medical Association is to be distinguished from the World Health Organization, the official health agency of the United Nations, and primarily a governmentally oriented body. WMA, however, does have liaison with WHO, and relationships with it and with other governmental agencies tends to be friendly and constructive.

Doctors of medicine the world over cherish the same basic ideals of conduct and the same devotion to the welfare of mankind. WMA is cultivating the common purposes of the profession. This grow-

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Dosage: Adults—1 tablet, swallowed whole to preserve timed-release feature, in morning, midafternoon and at bedtime. **Side effects:** Occasional drowsiness, blurred vision, cardiac palpitations, flushing, dizziness, nervousness or gastrointestinal upsets. **Precautions:** The patient should be advised not to drive a car or operate dangerous machinery if drowsiness occurs. Use with caution in patients with hypertension, heart disease, diabetes or thyrotoxicosis.

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ing community of interest is a source of strength to the physicians in every land.

By solid accomplishments in the fields of medical education and ethics, the World Medical Association has earned the right to call itself "the international voice of organized medicine."

Everywhere physicians are striving to preserve or —where they have lost it—to regain their freedom to practice medicine according to the dictates of their consciences and their scientific disciplines.

Leaders of organized medicine while recognizing the limitations of the World Medical Association's aid projects due entirely to lack of finance, have at the same time pointed out that had this Association not been brought into being in 1947, the physicians of the world would now find it imperative that such an organization be now created.

The present and potential benefits and achievements of WMA should enlist the support of American colleagues who wish to participate in such projects as: Establishing self-sustaining rural medical aid units in developing countries; providing professorial exchange programs between well established and new medical faculties; administering scholarship funds within the ethnic regions of the world; providing an efficient medical information exchange center; implementing the Fourth World Conference on Medical Education.

Three-Year Residencies in General Surgery to Be Phased Out

The Conference Committee on Graduate Education in Surgery, made up of representatives of the American Board of Surgery, the American College of Surgeons, and the Council on Medical Education of the American Medical Association, has decided to discontinue approving Type II (3-year) residency programs in general surgery after June, 1972.

Applications for the approval of new Type II programs will not be accepted after June 30, 1968. All such programs which are approved at that time will be required to qualify as Type I (4-year) programs, on their own or by affiliation, or be discontinued.

Denver Conference on Newborn

Children's Hospital, Denver, will present the Aspen Conference on the Newborn at the Aspen Institute for Humanistic Studies on February 5, 6, and 7, 1968.

Registration fee is \$40.00. For further information write: Aspen Conference on the Newborn, Children's Hospital, 19th Avenue at Downing, Denver, Colorado 80218.

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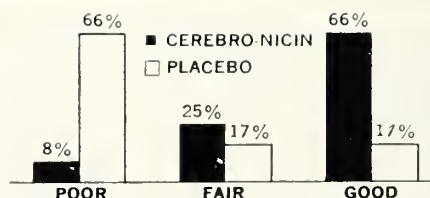
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*A Double-Blind Study of Cerebro-Nicin, Therapy for the Geriatric Patient, R. Goldberg, Jnl. of the Amer. Ger. Soc., June, 1964.

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Annual Licensure Report Shows Net Gain in Physicians

Another 8,596 licensed physicians were added to the U. S. medical profession in 1966, according to a report by the American Medical Association's Council on Medical Education.

As of December 31, 1966, there were 300,376 physicians in the U. S. The total includes 243,391 licensed physicians, a net gain after deaths, retirements, etc., of 3,768 licensed physicians from the same date a year earlier.

(The figures should not be interpreted as meaning that only the 243,391 licensed physicians were qualified to take care of patients. Thousands of physicians, working under various medical, educational, and military-service permits—including most interns and some residents, as well as military and other government-service doctors—contribute to patient care. AMA records indicate that as of December 31, 1966, approximately 267,000 physicians were involved in patient care.)

The AMA's 65th annual report on medical licensure statistics appeared in a recent issue of the *Journal of the AMA*.

There were 626 fewer physicians receiving their first license in 1966 than in 1965. There were,

however, 685 more than the total newly licensed in 1964.

According to the AMA report, Ohio licensed 309 doctors of medicine by examination, 556 on the basis of reciprocity and endorsement, or a total of 865. Of this number, 425 are considered additions to the medical profession. There were also 93 osteopaths licensed in Ohio, according to the report.

For the fourth consecutive year, California led all states in the total number of licenses issued with 2560, 97 less than the previous year. New York was second with 1871; Pennsylvania was third with 936; Ohio, fourth with 865. Texas, Maryland, Illinois, Michigan, Massachusetts, and Minnesota followed in that order. Each issued somewhat more than 500 licenses.

State Medical Board of Ohio Issues Certificates

Dr. W. Thomas Washam, Executive Secretary of the State Medical Board of Ohio, recently released a list of 80 doctors of medicine who were authorized to receive certificates to practice medicine in this State by endorsement of their licenses to practice in other states with which Ohio has reciprocity, or through certification by the National Board of Medical Examiners.

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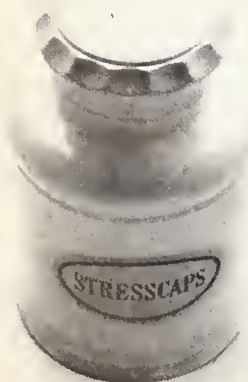
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Permanent Operating Room Laser Installed in Cincinnati

A permanent operating room laser, believed by persons associated with the project to be the world's first, was installed June 29 for research studies at the Christian R. Holmes Hospital of the University of Cincinnati Medical Center.

The high-output ruby laser was developed jointly by Spacera, Inc., and the research team at the UC Medical Center.

University of Cincinnati physicians have been doing research with laser operating room equipment on the use of laser beams in the treatment of cancer and other surgical conditions in humans.

Dr. William A. Altemeier, professor of surgery and head of the department in the UC College of Medicine, and Mr. Glenn A. Hardway, president of Spacera, Inc., of Burlington, Mass., announced the completion, installation, and successful preliminary testing of the equipment.

This equipment is part of the Medical Laser Laboratory at UC, housed in the Children's Hospital Research Foundation.

Grants from the John A. Hartford Foundation and the National Institutes of Health support the laboratory.

Tuberculosis Sanatorium of Long Standing Announces Closing

The Rocky Glen Sanatorium, McConnelsville, leading tuberculosis treatment center of long standing, is discontinuing operation under that name and transferring its remaining patients to other institutions. The Mark Rest Center which has occupied part of the facilities formerly included in the sanatorium is expanding to take over the entire installation.

Rocky Glen Sanatorium was started in 1911. In 1919 the facility was acquired by the late Dr. Louis Mark and expanded into one of the leading treatment centers of its kind in the country. For many years operated at its peak capacity of 150 patients, it had contracts with the Veterans Administration, United Mine Workers, Industrial Commission, Brotherhood of Railroad Trainmen, Department of Immigration, and with various counties and other organizations. Private patients also were referred.

The sanatorium has had its reverses. In 1924 and again in 1946, it suffered destructive fires, but came back each time with the building of more modern structures.

At the time of the announced closing, the number of tuberculosis patients had dwindled to 20.

Ohio Division of Mental Hygiene Sponsors Family Play Program

The Division of Mental Hygiene of the Ohio Department of Mental Hygiene and Correction is sponsoring the Ohio Family Play Program in cooperation with a number of Ohio universities and colleges. The program is geared to stimulate thinking and to further education in the fields of mental health, family living, and human relationships.

Family Plays are one-act dramas centering on aspects of family living. The plays are performed by troupes of student actors before community organizations. Each performance is followed by audience discussion of the issues raised by the play.

The plays are entertaining, and the booking organizations invariably enjoy the performances. But their real purpose is to stimulate thinking. Much of this is done through the post-performance discussions, led by a leader appointed by the booking organization.

Student actors from the participating colleges and universities are guided by a family play director, usually a graduate student. Each college or university also provides faculty supervision for the program.

Nine schools are participating in the 1967-68 season; Akron University; Baldwin-Wallace College, Berea; Findlay College; Kent State University; Lake Erie College, Painesville; Ohio State University; Ohio University, Athens; Xavier University, Cincinnati; and Youngstown University. Last season, eight schools gave 363 performances before more than 22,000 Ohioans.

Thirty-four plays are now available for the family players to perform. Each college or university usually chooses three of these for performance on a rotating basis. Plays take up such family living problems as working wives and mothers, parent-children relationships, juvenile delinquency, alcoholism, mental retardation, rehabilitation of a mental patient. The plays are professionally written and are obtained, for the

most part, through Plays for Living, a division of the Family Service Association of America.

A community organization may book a family play by applying to the nearest participating college or university. Each booking organization must agree to pay the nominal royalty, if required; usually these are \$1 or \$3. It is also desired that the agency guarantee a minimum audience of 45 persons.

College of Chest Physicians 1968 Cleveland Program

The American College of Chest Physicians, 112 East Chestnut Street, Chicago, has announced a series of 1967-1968 programs, one of them to be held in Cleveland.

The postgraduate program entitled "Cine Angiographic Techniques in Cardiovascular Disease" will be conducted in cooperation with the Cleveland Clinic, April 29 - May 1, 1968. Other postgraduate programs include the following:

Clinical Cardiopulmonary Physiology, Chicago, November 6-10.

Diagnosis and Treatment of Diseases of the Heart and Lungs, New York City, November 13-17.

Clinical Application of Cardiopulmonary Physiology, Los Angeles, February 12-16, 1968.

Diagnosis and Treatment of Cardiovascular and Pulmonary Diseases, Miami Beach, March 4-8, 1968.

Two Ohio physicians are among 15 selected for two-year residency fellowships in pediatrics under the Wyeth Fund for Postgraduate Education. This is the tenth group of fellows selected since the program was established in 1958 by Wyeth Laboratories. The Ohio physicians are Dr. Robert M. Baldwin, Columbus Childrens Center, and Dr. Aaron L. Kreisler, University Hospitals, Cleveland.

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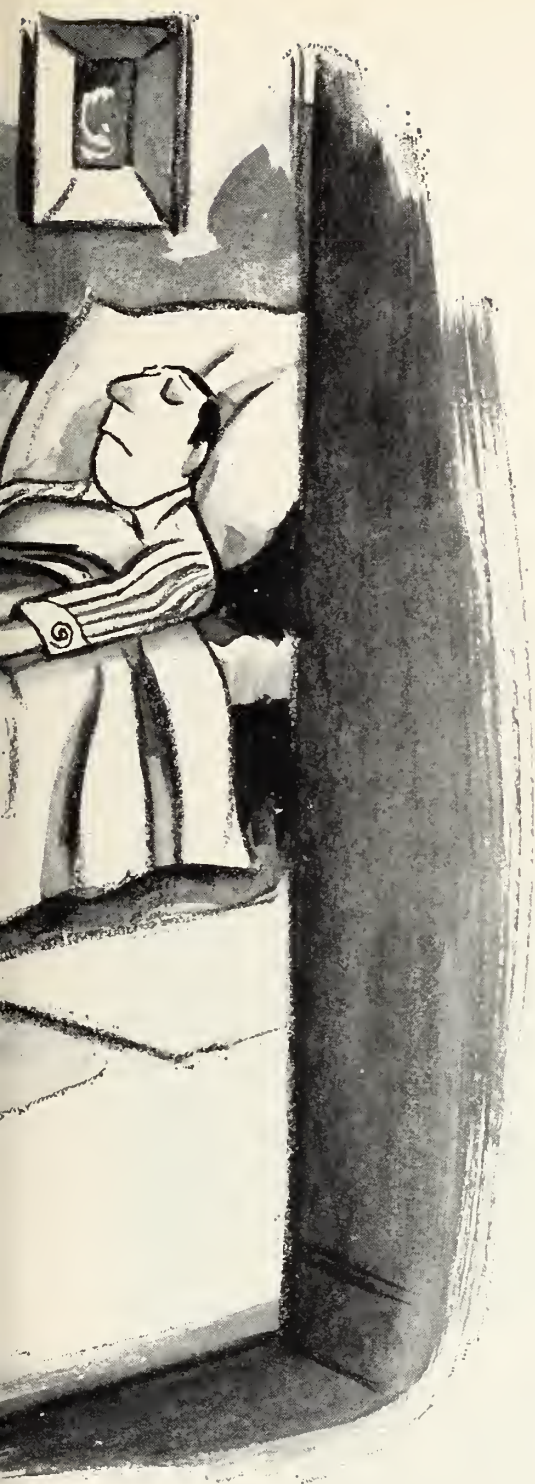
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3. Letters of introduction to foreign medical associations, facilitating professional contact when you travel abroad; attendance as an official observer in annual World Medical Assemblies.
4. A part in defending the interests of the medi-

cal profession in collaboration with other international groups.

5. The satisfaction of sharing the advantages of American medical know-how and progress with other nations of the world, and repaying a debt for the inspiration we have drawn from many countries and peoples through the generations.

Additional information may be obtained, or application for membership made, by writing The World Medical Association, Inc., 10 Columbus Circle, New York, N.Y. 10019. Annual membership is \$10; five-year membership, \$50; (tax deductible).

A meeting of the Southeastern Chapter, Society of Nuclear Medicine, will be held in the Phoenix Hotel, Lexington, Ky., October 19-21. Members, nonmembers, and radiologic technicians are invited to attend.

About eight out of every ten persons who drowned in boating accidents last year did not use the lifesaving devices which were carried on board, according to statisticians of Metropolitan Life Insurance Company.

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Cincinnati Radiological Heritage

The First Fifteen Years

STANLEY LUCAS, M.D.*

PART V

(Concluded from September Issue)

IN JULY 1909, the two old medical colleges of Cincinnati, the Medical College of Ohio and the Miami Medical College were united and brought into the University forming the College of Medicine. In 1909, announcement was made of the start of the building of New Eclectic Medical Institute on West Sixth Street at a cost of about \$50,000.

In August 1909, the *Cincinnati Lancet Clinic* announced the first society in Cincinnati related to the use of the x-ray with

It is a pleasure to record the organization on August 7 of a Roentgen Club, having for its purpose to discuss matters of interest concerning the diagnostic and therapeutic uses of the x-ray. The bringing together of men who employ the ray for diagnosis and therapy means more than appears on the surface. These physicians are among the most progressive students in our city. They are consulted by many of their confreres every week, they possess the confidence of hundreds of patients. Heretofore there was no cohesiveness, no common purpose to actuate them in laboring for the advancement of their speciality. The rivalry of the different schools, the varying impulses governing men on a high tension, the emulation of scientists to excel—these things have produced a most peculiar state of affairs in local medical circles.

The organization of this club—the word “club” seems to imply more informality and sociability than “association”—will have a far reaching influence. The mere fact of its existence will render easier the storms which some have predicted will follow in the wake of the medical school consolidation. The *Lancet Clinic* extends its best wishes to the Roentgen Club for a long and successful career.

The following are the Charter members: Drs. Lange, Dunham, Whitacre, Rieker, Juettner, Paul and Webb. Dr. Dudley Webb was elected Secretary. The club believes in rotation in office as far as its Chairman is concerned, who will be elected monthly. He will entertain the members while holding that exalted position. . . . The *Lancet Clinic* has been designated the official organ. All papers and abstracts of recent discoveries and advances will be prepared by the Club for publication in its columns.

In 1909, Dr. Dunham asked

Is the therapeutic application of the x-rays as much in vogue today as it was sometime since? It is true that less has been seen of this subject in the journals in the last 2 years but it is also true that much more of it has found its way into the standard text books and into bound volumes. The first assertion and denials are over, and men are settling down to a scientific study of the results obtained.

Dr. Dunham described the placement of a thorium nitrate bag in the x-ray beam to increase its effects (the use of a filter). He continued,

most editors of medical journals must have felt their inability to properly criticize articles dealing with electrotherapy especially since the application of the x-ray and radium to medicine have carried the subject far into the realm of physics. A lack of caution has at times brought certain journals into the embarrassing light of ridicule. To what extent these editors ever know their mistakes is a subject often affording amusement at yearly gatherings of the x-ray men.

He called an article in *The Journal of the American Medical Association* “entirely misleading, based on false concepts, and possibly leading to a suit for damage.”

At the 10th annual meeting of the American Roentgen Society held in Atlantic City in September, Dr. Sidney Lange spoke on the subject of the “X-Ray Examination of the Mastoid Process.” He and Dr. Samuel Iglauer, a voluminous writer in his speciality of Ears, Nose and Throat, and later nationally known for his work in the field of plastic surgery and radiology as related to his specialty and also Professor of the Department of ENT at the Cincinnati General Hospital, had worked on dried skulls, fresh cadavers and a considerable number of patients attempting to develop positions and techniques for visualization of mastoid and middle ear disease. Together they published a paper on these subjects in the *Journal Annals of Odontology, Rhinology, and Laryngology*. Dr. Iglauer, alone, published a paper on “Mastoid Radiography” in the *J.A.M.A.* toward the end of 1909.

Dr. Lange was also writing and speaking on many other subjects including “Isolated Fracture of the

*Dr. Lucas, Cincinnati, is Radiologist, Jewish Hospital; Attending Radiologist, Cincinnati General Hospital; Assistant Clinical Professor of Radiology, The University of Cincinnati College of Medicine.

Submitted October 24, 1966.

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Head of the Radius" and "Some Observations on the X-Ray Study of 25 Cases of Aortic Aneurysm." In February, 1910, he read before the McDowell Medical Society a report of a case of an annular carcinoma of the esophagus, diagnosed by x-ray in which he used not only a capsule containing bismuth but also a swallow of mush containing subcarbonate of bismuth, apparently one of the first reports in this area of a liquid contrast meal.

A new medical school, the Cincinnati Polyclinic and Post-Graduate School, announced in 1909 its staff which included Dr. Otto Juettner as teacher in therapeutics and radiography.

In 1910, the *Cincinnati Lancet Clinic* wrote

Few men in the profession of medicine seem to realize that some epoch making work has been done in the domain of the x-ray right here in Cincinnati, work that is being discussed in every part of the world. A bright physicist in the University of Cincinnati, Dr. S. J. Allen, and Dr. H. K. Dunham, a man well versed in x-ray work and a member in the teaching staff of the Medical Department at the University, began an investigation to determine, if possible, if an accurate knowledge of the quantity and quality of the rays could be obtained. They have succeeded admirably and are yet modest enough to call their work merely preliminary. The demonstration of their method is published in the *Archives of the Roentgen Ray* for January, and entitled "The Physical Measurement of X-Rays." The ionization method is the one used by these investigators. For the simple measurement of quantity of the rays, the electroscope, under suitable conditions, is used. Their work is being recognized wherever radiography is discussed.

Dr. Dunham, truly a scientific giant, presented to the Academy of Medicine a talk on "Stereoscopic Radiograms of the Chest." He claimed no priority for this technique but claimed greater accuracy, owing to a reduction in time of taking the two exposures. He used a "Gabler" screen (intensifying screen) containing calcium wolframite for its fluorescent properties. Dr. Dunham also experimented with the use of uranium and mercury solutions for intensifying the plates during development in order to shorten exposure. At this time, he prophetically said "it appears that it will be possible to so reduce the x-ray exposure as to secure a perfect picture from a struggling and crying child or to radiograph a heart either in systole or diastole."

In 1910, Dr. Dunham was also relating to medical Cincinnati further details of intensifying screens, using tungstate of calcium as a fluorescent crystal. He noted that at first the screens gave a very granular appearance to the plate because of the coarseness of the crystals but that the newer screens were using amorphous material. He spoke of the Gehler screen—from the Polyclinic of Leipzig—invented by Hoffman and Roster and based on the previous work of Drs. Biesalki and Kohler which was reported at the Berlin Congress in 1909.

Further prophetic imagination of Dr. Dunham prompted him to write "with the proper apparatus perfect moving pictures could be secured of the

heart, diaphragms, and chest wall, and our knowledge of physiology and pathology might be augmented." [A prediction of our cine radiography of today.]

In reviewing a book in 1910 entitled "Medical Electricity and Roentgen Rays" by Sinclair Tousey, The *Cincinnati Lancet Clinic* noted that "No question which could arise in x-ray therapy is overlooked" [in 116 pages!—so much knowledge and yet so little!]

The deaths of early operators and investigators of the x-ray were occurring and the journals noted that although extremely lamentable, these were often due to the fact that x-rays were being employed by those who had inadequate knowledge of the underlying physical and physiological principles and realized that to use the roentgen ray one should have a properly qualified operator who understood the shortcomings and the problems of protection.

Dr. S. P. Kramer, in 1910 presented an article in the *Cincinnati Lancet Journal* illustrated with x-rays demonstrating a case of chronic obstipation thought to be due to coloptosis and repaired surgically. Dr. Kramer, with his first x-rays of keys and metal objects, February 24, 1896 and a case report in 1910, opened and closed the first fifteen years of radiology in Cincinnati.

Industrial Cincinnati

The careers of two men, J. Robert Kelley and Albert B. Koett, began long before the turn of the century at points separated by thousands of miles. Mr. Kelley of Old Virginia became interested in things electrical through his occupation of stringing telegraph wire across the countryside. Mr. Koett of Sachen Weimar, Germany was an Old School precision craftsman. The paths of these two men crossed in Covington, Kentucky, at the turn of the century, where in a small shop in the back yard of Koett's modest cottage, the humble beginnings of the first Kelley-Koett plant were housed (now known as Keleket). One of the early products was a wooden x-ray tube holder, a great improvement for the time and moderately priced at \$10.00. In 1905, they made the "Grosse Flamme," the first successful generator to draw a flame of 12 inches as compared to other coils which produced only a few inches of spark. Other early products of Keleket included a Titubator, a mechanical rocker which agitated glass plates during development to secure more uniform results. Keleket's first major national advertisement was in the first issue of the *American Quarterly of Roentgenology* (*American Roentgen Ray Journal*) in 1906.

Summary

The first years after the public announcement of the discovery of the roentgen ray were years filled with amazement, wild claims, lack of caution, exuberant expectations inviting quackery, jokes, cartoons, and disaster to the unwary explorers. Then came the period of more thoughtful evaluation, scientific approach,

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realization of limitations, sound hopes with expectations for the future and more comprehensive knowledge for the safe utilization of this new miracle ray. Organizations were then founded to group together men joined by their common interests for the sensible, rational use of the roentgen ray and radium. New equipment and accessory advances making possible modern Radiology were already being reported; better tubes, better sources of power, intensifying screens, and improved methods of development of the glass plates.

In the last years of this 15-year pioneer period, articles of lasting value were written and sound basic research was being done on the use of the x-ray diagnostically and therapeutically. Much of this work stands unalterable to this date. In Cincinnati, as elsewhere, the early radiological workers came from all branches of medical practice including electro-therapeutists, surgeons, urologists, orthopedists, ophthalmologists, urologists, and physicists. The contributions of several Cincinnati physicians brought them national and international fame.

This is the early history that represents the firm foundation upon which the specialty of Radiology

could grow to become today such an integral part of medicine.

The author wishes to thank Miss Phyllis Toms and Miss Jane Hutzelman for expert secretarial and photographic assistance, respectively; Mr. Gordon Templar for his personal communications regarding Keleket Corporation and associates Drs. Lee S. Rosenberg, Harold N. Margolin, and Archie Fine for their encouragement of this project. Dr. Benjamin Felson is thanked for his being a continual inspiration.

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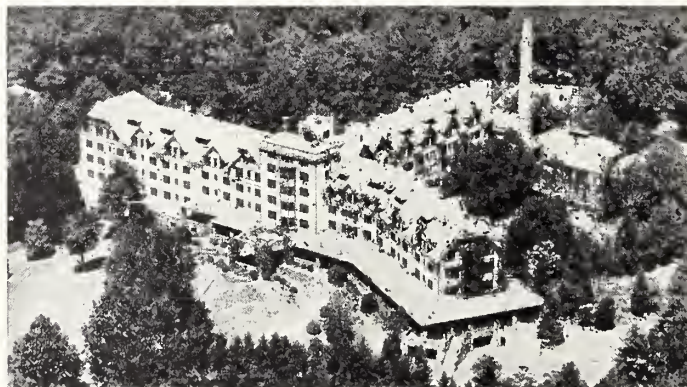
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Dr. Richard H. Keates, associate professor of ophthalmology at Ohio State University, has received a \$2,100 research grant from the National Society for the Prevention of Blindness. The grant is in support of his investigation of the possible harmful effects of intravenous injections of fluorescein, a dye used in the study of retinas.

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Scientific Section

VOL. 63

OCTOBER, 1967

No. 10

Coronary Care

A Challenge to the Small Community Hospital

L. A. BLACK, M.D.

THE CONCEPT of the Coronary Care Unit with its gadgetry and specially trained nursing personnel has revolutionized the care of the patient with myocardial infarction. It offers the patient with such a problem a much improved outlook but at the same time it poses a quandary to the small hospital. Is such an area feasible? Can it be carried financially? Can adequate nursing personnel be allotted to it? Can they be properly trained to achieve the goals in such a unit? Finally, can the general physician, without a house staff, adequately handle this sophisticated instrument and achieve better patient care?

Coronary Care Units in the large hospitals in this country have demonstrated that mortality rate *can* be lowered. Unless this revolution spreads to the small hospital, however, the one hundred thousand lives which could be saved annually will remain a paper figure. Current interest on the part of small community hospitals everywhere is now great. Many institutions are actively planning or considering planning such units. We have dealt with this problem in our hospital by construction of a unit to serve both Intensive Care and Coronary Care needs. We report our experiences and conclusions at the end of the first year of operation.

Background

Hardin Memorial Hospital is comprised of 110 beds in two separate buildings located in Kenton,

The Author

● Dr. Black, Kenton, is Chief of Staff, Hardin Memorial Hospital; former Chief of Medicine, and Head of Intensive-Coronary Care Committee.

Ohio, a community of 9,000 people. The area served by this hospital encompasses about 30,000 people. There are 22 attending physicians, two of whom are general surgeons and two are internists. The remainder of the men are general practitioners. The scope of the work done at the hospital is rather general without involved orthopedic injuries and without neurosurgery.

We had evaluated our needs for Intensive Care from about 1962. We had reasoned that because of the low incidence of trauma and neurosurgery our surgical utilization would be considerably less than medical utilization. We felt we could combine the treatment of the coronary care patient with the intensive care patient more successfully than other institutions had reported.

Approximately a year prior to our opening, an Intensive Care Committee was appointed. It was comprised of three physicians, the administrator, the maintenance engineer who was to be responsible for the development of the area, and the nurse who would ultimately be in charge of the area. This combination of viewpoints was brought to bear on all the problems of the unit. We found that early

Submitted June 2, 1967.

discussions by and visitations by the entire group did much to insure the ultimate success of the project.

Problems

Physical Space:

At the time of our decision to open this unit, we were contemplating a new addition to the hospital and we were extremely short of space, but the decision was made to proceed in order to gain experience. A small nursery was converted into an Intensive Care Room. The total footage was approximately 600 square feet. We were unable to provide for compartments or private rooms of any kind in this area without rendering it functionless. At the same time, we were able to dispense with any kind of slave monitoring because our nursing station, centralized as it was, was close enough to the patient units to permit direct observation of the bedside monitors by the nurse.

We looked at a number of Intensive Care Areas and discussed space utilization in these, particularly with the nurses. We found them to be the experts on how their areas really functioned. We tried to plan carefully the utilization of our space in such a way as to make it a totally self-contained unit with its own supplies, etc., and at the same time aimed not to clutter it to the point where it was unpleasant for the patient. We gave a great deal of attention to all of the methods we could devise, or that had been thought of by others, to keep noise at a minimum. In this connection, the discussions between nursing and maintenance departments were of utmost importance and ultimately served us in good stead.

Personnel:

We faced the same problem of shortage of nursing personnel as had other areas we had contacted. We too found that awareness of nursing shortage threatened such a program before it ever got off the ground. It required a lot of enthusiasm on all sides, staff and administrative, to push through the rather general concern about shorting nursing in other areas. Six nurses in all were selected, as well as a number of aides. Three weeks prior to the opening of the unit these were moved from general nursing duties and assigned to education classes. The period of education was overseen by the nursing supervisor who by this time had attended some courses and acquired some knowledge by visiting other units. The staff participated actively and lectures on various subjects were taped. A number of tapes were borrowed from a nearby Intensive Care Unit. These were considered invaluable. One day's program was carried by the local Heart Association with participation by visiting nurses and physicians. These three weeks, we felt, were critical to the success of the unit.

We decided early to continue on a regular basis continuous education particularly in electrocardi-

ography, cardiac pharmacology, the treatment of acute arrhythmias and, finally, defibrillation by nurses.

On May 2, 1966, the unit opened. We would like to review our experience, draw some conclusions, and make some suggestions.

Results

Table 1 lists our overall mortality rate for all types of patients: the mortality rate for myocardial infarction occurring in the unit regardless of the patient's condition on admission, and the mortality rate

TABLE 1. *Statistics Relative to Coronary Care*

Patients	Total	Deaths	Per Cent
Patients—All types in unit	180	24	13.3
(Medical; surgical; coronary)			
All myocardial infarcts in unit	64	8	12.5
Myocardial infarcts in unit occurring in patients admitted for coronary care	61	5	8.2
All infarcts during entire hospital stay	64	12	18.7
Significant arrhythmias recognized in myocardial infarction	48 (75%)	..	..

for myocardial infarction admitted directly for coronary observation. The most important statistic is the total mortality rate for the entire hospital stay. Three of our deaths were terminal on admission from other hospital areas and would not have been admitted to most Coronary Care units in hospitals equipped with Intensive Care Areas. One of our deaths was due to arrhythmia—complete heart block associated with shock in an 84 year old patient. The only case of primary ventricular fibrillation occurred just as a patient was being admitted to the unit and was successfully treated by defibrillation.

Our statistical analysis as it applies to coronary disease is a pleasing though not a suprising finding. We had the advantage of opening a unit at the time when the concept of active treatment was well established by others. Our entire experience has been associated with aggressive management of myocardial infarction. In our unit all patients are placed on intravenous catheter and are maintained on it until discharge. Our average stay for the coronary patient is about seven days. Intravenous anti-arrhythmic agents are used freely and at the discretion of the nurse who is also charged with notifying the physician. Our incidence of detected arrhythmias is 75 per cent, somewhat lower than that reported by Drs. Meltzer and Kitchell. Considering the fact that the unit is also used as an Intensive Care Room we feel that the detection of this percentage of arrhythmias is a reflection of the quality of our nursing care, as well as the structure of the room.

As others have pointed out, a statistical analysis in an area such as this can be very difficult to interpret because of selection of patients, duration of stay, time between onset of attack and presentation of the patient to the unit, etc. In short, the early deaths can be screened out by inept care, delay in transit,

failure to recognize infarcts on the part of the physician. The late deaths can be screened out by early transfer to the floor, etc. Allowing for these, we feel our overall mortality rate of 12.5 per cent for myocardial infarction admitted directly or after a disaster on the floor, represents some degree of success. We feel that our lack of deaths from tachyarrhythmias reflects awareness in detection and aggressive and early treatment of the early arrhythmias by the nursing staff.

We entered the field of coronary care with enthusiasm and our opinions not based on statistics are suspect. It is apparent to all of us involved, however, that the incidence of bad results in bad-risk patients

TABLE 2. *Coronary-I.C.U. Statistics*

	Total No.	Deaths
All patients	180	24
Suspect M. I.	106	7
Definite M. I. (confirmed by ECG and Enzymes)	64	7
Coronary artery disease without infarction.....	36	0
Coronary observation — no diagnosis	6	0
Significant arrhythmias without infarction	5	0
ASHD with acute pulmonary edema	10	3
Massive CVA	6	4
Massive pulmonary embolus	3	2
Other medical conditions	36	4
Surgical problems	14	4

of all diagnoses decreased strikingly under active treatment of these problems in the unit.

There have been more subtle benefits accrued to our institution:

1. Mortality rate for acutely ill medical patients of all kinds seems to have decreased. The ability to carry out effective care of these problems has impressed everyone involved.
2. The level of nursing care in the entire hospital has improved and should continue to improve. During the second six months of operation head nurses of other departments have rotated through the Intensive Care Room as a visitor and student and have carried back some of the procedures to their own areas.
3. The development of effective respiratory resuscitation in the small hospital has been greatly facilitated by this unit and should continue to improve in the months ahead.

Discussion

Feasibility:

Much of our early concern centered around the question as to whether or not we could in fact effectively combine an Intensive Care Unit and a Coronary Care Unit. The coronary patient required nursing sophistication, as well as patient relaxation and confidence that he was receiving the maximum amount of care. Most reports on coronary care in recent years have emphasized the desirability of isolating coronary patients who require prophylactic nursing

care from active treatment centers. Of course, this is really impossible in a small hospital because of the shortage of personnel and total numbers of patients of each type.

Because of our size, lack of trauma and neurosurgery, and perhaps our emphasis on coronary care from the beginning, we found that our overall mortality rate was low enough so as not to pose a frequent threat to the patient on coronary observation. We found our nursing personnel were able to devote a great deal of their attention to coronary care. Our recognized incidence of arrhythmias is certainly acceptable and we believe reflected the advantages of direct observation. The active treatment of the arrhythmias with intravenous arrhythmic drugs brought our incidence of ventricular fibrillation down to zero, except as it complicated terminal shock and in one case as it occurred on admission.

All of our patients received questionnaires as they left the unit asking for comments on care, feeling of security, need for more isolation, etc. With no exceptions we found the patients to be enthusiastic and at least unaware that they might require more privacy.

In general, then, we felt that it was feasible to combine an area such as this if concern was given to patients' attitudes, prevention of noise, relative isolation, and feeling of security.

Utilization:

We were surprised at the low surgical utilization, the more so because our surgeons were enthusiastic about Intensive Care and about the unit. In trying to analyze why, we discovered that at no time were patients referred to the unit because they represented serious surgical problems or problems requiring close surgical nursing observation. In short, patients referred to this area from the surgical floor represented major complications such as massive pulmonary embolization, associated disease such as mitral stenosis, problems complicating their surgical care because of associated diagnoses such as carcinomatosis. In other words, this unit has not been used to replace good surgical nursing care and reflects the confidence of the surgeons in the quality of the care the patient receives in the recovery area and surgical floor.

The total patient utilization during the year has averaged between 50 and 60 per cent. During the month that we averaged over 80 per cent several patients were displaced by other patients with more serious problems. In no case has the officer of the month had to enforce a decision as to which patient should be transferred to the floor. The unit nurse in charge has contacted the physician responsible for the patient who seems best able to be transferred to the floor and in this way an effective priority system has been maintained.

Education:

The major problem in a unit such as this in a small community is education. We felt we were

settling for less than an ideal circumstance when we relied on our own backgrounds mainly to initiate the education of our personnel. At the time there were no alternatives. In the near future we assume there will be many since more and more institutions are providing periods of education for key personnel.

Initial education is only a part of the problem as we see it. At least as important is continuing education of the personnel who remain and the education of the personnel coming new to the unit. In a small hospital this is difficult indeed because the unit is constantly threatened by nursing shortage and substantial numbers of personnel cannot be released for even a few days retraining.

Our continuous training program has consisted of in-service demonstrations at times of low patient census or during the rare period when there are no patients in the unit, repeating training in cardiopulmonary resuscitation, repeating training in respiratory resuscitation and ECG monitoring. A nurse new to the unit comes in for a period of one to two weeks observation and is exposed to the taped lectures which we have accumulated, and is gradually given more and more education until she is felt to be responsible enough to initiate emergency treatment for the arrhythmias. Until that time she is dependent on the advice of the nursing director and the physician in charge of the unit. It is not an ideal situation but it has served us adequately and it has continued to develop new nurses as we have required them.

Education — Future:

The key to the problem of education is in the scarcity of educated and interested physicians and small numbers of nursing personnel. This is a continual problem and its solutions are not wholly apparent to us. Recently we have purchased ECG monitoring tapes of various arrhythmias combined with a lecture. We feel this is a definite advantage in the training and retraining of the nurse in arrhythmias. Further tapes are being developed by the company at the present time.

In our general area of the country there has been a great deal of discussion about education and educational needs but each hospital is carrying out its own educational program as best it can and this must vary considerably depending on the personnel available.

We should suggest something like the following:

An organization such as the Heart Association or Regional Medical Planning should take the basic responsibility for devising a correlated program in an area. It should be organized around a medical center or a recognized center of some type. The medical center should be responsible for two types of training programs:

1. *Physician Training Program* where interested physicians out in the community hospitals can come for a short course on:

- a. Coronary Care Unit Fundamentals.
- b. Fundamentals of Training Nursing Personnel. A training program complete with slides and slide lectures could be supplied. The Physician Trainee in turn could return to his unit to be in part responsible for nursing education.

2. A program could be developed for nurses who would head Intensive Care Units or Coronary Care Units. This should include discussions of coronary care as well as problems of intensive care generally since most of the smaller hospitals would probably have some type of combination care.

The above two programs would need to be repeated perhaps every two to three months in the center, perhaps more often at first depending on the utilization.

3. The problem of continuing education should be decentralized and made the responsibility of smaller areas — several hospitals or several counties depending on the organizational structure which leads the way. These areas could maintain a monthly program of a few hours; e.g., four to six hours which could be offered repetitively. The same program could be offered twice each month or twice each two months so that more hospitals could cut loose one or two of their personnel without crippling their operation on a continuing basis of education.

It would seem to us that although this be a rather complicated interrelationship, the three elements of it — the central education of physicians and head nurses and the peripheral reeducation on a more local collective basis — are necessary to make the program successful in the small community. At the present time the Central Ohio Heart Association is considering such a program with all its interrelationships.

Summary

We have reviewed our experience with a small hospital Intensive Care and Coronary Care combined unit the past year.

We have found it feasible to combine these units. We feel our mortality rate is in line with the experience of other purely coronary care units.

We have discussed some of the problems of the small hospital operation as we have seen them, and have made some suggestions as far as the difficult problem of education of personnel is concerned.

Suggested Reading

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Infection Control in a Community Hospital

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IN A recently published book on infection control,⁸ the authors make the following statement: "Congregating a large number of sick people under a single roof has many advantages, but one serious drawback—that the disease from which one is suffering may be transmitted to others." This is a very obvious statement, but the fact that nosocomial infections do still occur indicates that knowing the truth is not sufficient to produce desired results. This knowledge must be accompanied by positive action under knowledgeable leadership.

Two physicians from the University of Virginia School of Medicine became aware of the lack of infection control exercised in the community hospitals of that state and conducted a survey of the facilities and procedures of 17 of these hospitals.⁹ The data collected clearly pointed out that administrative problems concerning isolation procedures existed in many hospitals. This point was illustrated by information submitted in data tabulated from the survey; e.g., 7 of the 17 hospitals had no clear list of diseases requiring isolation. Only 8 out of the 17 had strict formal procedures. In 16 of the 17 hospitals, the Infection Committee delegated the responsibility for guidelines to the nursing service and the Infection Committee in all cases was purely advisory.

We feel that Grant Hospital is one community hospital, which has been successful in establishing sound and effective control procedures and that other hospitals may follow this example. We hasten to point out, however, that success in this area requires considerable effort and cooperation from all departments and areas of practice including the medical staff. We also feel that a significant key is the service of an infection committee coordinator.

History of the Grant Hospital Committee

In August, 1958, The Joint Commission on the Accreditation of Hospitals recommended that each hospital establish an infection committee. The function of the committee recommended was to develop procedures that would control cross infection in the hospital.

One of Grant Hospital's surgeons had expressed his concern over this problem for some time. In 1958,

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when he was President of the Medical Staff, he decided that this was the time actively to pursue the many ramifications of the problem. He reviewed some of the procedures followed in the Grant Hospital Surgical Suite and made some concrete recommendations. His warnings were heeded and other members of the medical staff and hospital staff joined in and helped support his efforts. Sterilization, skin preparation, and aseptic techniques showed marked improvement, and shortly thereafter the Grant Hospital Infection Committee was established. The surgeon who was instrumental in the establishment of the committee was named chairman, and the hospital Pathologist, who shared the chairman's views and enthusiasm on this subject, was named co-chairman. The first official meeting of the committee was held in August, 1958.

The Infection Committee in its early history established some procedures for detecting sources of infection. Various hospital departments were notified of hazardous conditions and practices that came to the attention of the committee members. Infected hospital patients were isolated, but the committee was totally dependent upon the physician to report all cases of infection. However, the busy practicing physician often failed to report infected cases promptly, usually because he did not remember or was not familiar with the procedure. The failure of

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this system of reporting soon became evident and recommendations for new procedures were made.

Not until 1964 did the first full-time Infection Control Coordinator come upon the scene. Control procedures have improved enormously since this was accomplished. This was the link that closed the gap in the infection control process. The coordinator is needed to police and interpret procedures established by the committee. Without her, many established procedures are poorly understood by the people who are to carry them out and few violations of these procedures are clearly observed.

Gradually, many other departments who play a part in the overall infection control process were invited to join the committee. More will be said about these departments.

Organizational Structure

The Infection Committee at Grant Hospital consists of 14 members who represent nine different departments. A surgeon serves as chairman, and the hospital pathologist serves as vice-chairman. Minutes of the meeting are taken by the medical staff secretary. The Infection Control Coordinator supplies materials for discussion at the meeting from a record of her activities during the month. Other discussions center around items presented by the committee members representing the various hospital departments and subcommittees.

Policies governing the activities of the Infection Committee are formulated, written, and distributed to the medical staff and other groups which these policies affect.

The function of the committee is basically that of recommending. Problems that come before this body are acted upon and are usually referred to the Executive Committee and/or the Administration. Problems submitted by individual hospital departments get a reply from the Infection Committee, but any major change involved must be approved by the administration.

The Executive Committee has authorized the Infection Control Coordinator to culture draining wounds under the supervision of the Infection Committee Chairman. The isolation regulations are also approved by the Executive Committee.

The Infection Committee Coordinator

In April of 1964 the first full-time Infection Control Coordinator was employed at Grant Hospital. Prior to her employment, the members of the medical staff carried the full responsibility of reporting cases of infection. The staff member was to report these infections to the hospital pathologist, who is co-chairman of the Infection Committee. This plan appeared to be a sound idea and had many merits, but it was soon recognized that to depend upon the busy physicians to report all cases (100 per cent) of infection was not conducive to a broad, effective

control. Following recognition of this deficiency, a proposal was submitted to the Hospital Administrator to employ a full-time coordinator.

The proposal suggested that this person be a registered nurse and, if possible, that she have some experience in infection control techniques. Many authorities who write on infection control believe that ideally the Infection Committee Coordinator should work under the direction of the Administrator, leaving her free from the control of any one department head. In practice, however, most coordinators, who usually are nurses, function as members of the nursing staff. Although in practice, having her in the Nursing Department does seem to work, it seems more logical from an organizational standpoint to have her work with Administration. At the present time, it seems that one can only watch to see what answers future practices will bring regarding this question. Following the Coordinator's joining the staff at Grant Hospital, there came a marked improvement in the results of the Infection Committee activities. The following is a list of some of the duties of the Infection Control Coordinator:

1. Confers with the night supervisor each morning in an effort to locate any patient who has been admitted during the night with a possible infection.
2. Maintains a record relating the location, isolation, and general treatment on all patients with a possible infection.
3. Visits all nursing stations, confers with the charge nurse on each station, and checks temperature charts in an effort to locate and watch the progress of any possible infection.
4. Visits the Admitting Department and obtains their list of possible admissions with infections.
5. Makes rounds of all other patient areas such as Surgery, Recovery Room, Nursery, Emergency Room, Intensive Care Unit, et al.
6. Makes routine cultures of environmental objects in all patient areas. This includes culturing walls, furniture, fixtures, and personnel.
7. Makes a daily check on culture reports submitted by the Bacteriology Department.
8. Follows and keeps record of all problems concerning infection control along with other special duties. Some of these include inspection of autoclaves, follow up any positive culture, submit test cultures on key personnel, transport carts, and other environmental objects, observe infection control techniques of hospital personnel.
9. Confers with physicians on isolating patients.

The Role of the Medical Staff

The medical staff plays an important role in hospital infection control. This is true not only from a technical standpoint, but also in the public relation aspect of this problem. The physician's cooperation is needed because patients being admitted with drain-

ing wounds or other signs of infection should be isolated upon admission. It is a tremendous help to the hospital if the physician informs the Admitting Department when he reserves the room that the patient has a draining wound or has been exposed to a contagious disease.

The hospital establishes admitting procedures regarding infectious cases because it recognizes that this is necessary to the safety of other patients and hospital personnel. This, however, does not complete the job. Often the family must be prepared to accept the fact that their relative is going to be isolated. Preparing the family for this acceptance often requires the skill, tact, and knowledge of the physician. Frequently, he is called upon to explain that visits must be limited and that each visitor must wear a gown and abide by all the other rules the hospital has established regarding infection control. The hospital is therefore dependent upon the physician's cooperation in this matter. At the same time the hospital owes it to the physician to familiarize him with its procedures and make certain he fully understands the reasons behind every rule. He must be fully prepared to do the public relations work required to attain proper cooperation of the patient and his family.

From a legal aspect, the activities of the Infection Committee work in favor of the physician as well

as the hospital. If an unfortunate incident were to occur, the physician, the hospital, the family, and the public will take a more positive attitude if every possible precaution has been taken to prevent such an incident. It is also less likely that legal proceeding will take place and fall in favor of the plaintiff if proper precautions have been exercised.

The thoughtful clinician can promote better infection control also by setting a good example. House staff officers and nursing personnel will often take a rule lightly if the physician does not respect it. On the other hand, if the physician carefully observes good, acceptable techniques, others will try to observe them. It is, therefore, clear to most people involved in infection control that, if we are to succeed in maintaining quality infection control, we must gain the cooperation of the medical staff. One of the prime reasons infection control has become successful at Grant Hospital is that the medical staff is concerned about cross infection and lends its vital support to effective control procedures.

Functions of Hospital Departments

All efforts of infection control are futile unless they are carried to completion. Every link in the control process must be strong and effective. It takes only one weak link to nullify the effect of all other efforts put forth to establish an effective control. It



FIG. 1. Cubicle isolation in a 2-bed room.

is therefore necessary for almost all hospital departments to participate in the infection control process. Departments which do not come into direct contact with the patient must lend their support to the procedures established by the Infection Committee. The following paragraphs describe some of the contributions made by various hospital departments.

Dietary Department:

One of the most important departments in the infection control process is the Dietary Department because it reaches such an overwhelming per cent of patients and personnel. Lack of proper control in procedures in this department can be disastrous. Diarrhea caused by a salmonella infection in one or two employees can reach epidemic proportions rapidly if unchecked. The Dietary Department at Grant Hospital takes stern measures to produce meals that are not only attractive, nourishing, and tasty, but also safe for the patient and employee. Rigid specifications are established to control storage temperatures, cooking temperatures, and serving temperatures on both hot and cold foods. Wherever possible, foods like eggs that are used in noncooked items like eggnog, are not used in the original form, but replaced with a substitute like their pasteurized counterparts.

Dishwashing is done by a prescribed process, where water temperatures are controlled; specific amounts of detergents are used. Disinfectant solutions are discussed and approved by the Infection Committee.

Dietary personnel undergo rigid inspections according to a checklist of items to be inspected. The list is as follows:

General appearance, good posture, clean well-fitted uniforms, neat well-kept hair, clean hands, clean well-kept nails, clean skin free of boils and blemishes, clean teeth, absence of body and mouth odors, and the absence of colds and other respiratory difficulties.

Any employee absent due to illness is directed to report to the outpatient clinic and receive a clearance before returning to duty. These inspections are made, of course, in addition to the regular physical examination.

The Laboratory:

The Bacteriology Department is, of course, one of the indispensable factors in an infection control program. It is from their procedures we determine when a concrete problem exists and through which we measure the effectiveness of the entire program. It is obvious to all persons engaged in infection control that objects may appear scrupulously clean and not be free from contamination. We must rely upon the Bacteriology Laboratory to be the control agency and determine when a contaminated condition does exist.

The Infection Control Coordinator must work closely with the Bacteriology Personnel. The Co-

ordinator visits the Laboratory daily and reviews the positive cultures. Some infection sources are detected in this manner.

One of the most important individuals serving on the Infection Committee is the Pathologist. The committee meets only once per month, but during this period, the Infection Committee Coordinator consults with the Pathologist many times. She must depend heavily upon the advice of the Pathologist in many instances where the judgment of such an expert is required.

The Pharmacy Department:

The choice of disinfectant agents must be considered carefully, but such a task represents a vast undertaking. Registered with the United States Department of Agriculture are 8,000 disinfectant and cleansing agents, all of which claim to be better than the next for one reason or another. These agents must be reviewed, making note of their chemical composition, their strength, their effectiveness, their limitations, precautions, etc.; and from this search, one or more agents are chosen for use in the hospital.

In such a task, the Pharmacy Department can be a valuable aid and can be depended upon for sound guidance in choosing proper agents for effective cross infection control. In performing such a task, the pharmacist must, however, be educated in evaluating the information on this subject. Much of the information, particularly that of an advertising nature, can be easily misleading. Many elaborate charts and graphs can present factual information concerning a product yet lead to an irrational or false conclusion. One reviewing the literature for this information must look for sound data obtained from controlled studies leading to an unbiased conclusion.

The Pharmacy Department must also observe good technique in preparing medications for patient use. Irrigating fluids and other preparations that are intended for topical use can cause difficulties when used without being sterilized. Sterile procedures must be applied to many such products so as to insure that contamination is not spread.

At Grant Hospital disinfectant agents used in all departments are listed and specified. Each department wishing to change its disinfectant agent must first request the approval of the Infection Committee. In these activities, the committee receives the assistance of the Pharmacy Department.

The Nursing Department:

The functions of the Nursing Department in the overall effort to control nosocomial infections are numerous and far reaching. Their activities may be broken down into those which take place in Surgery, Obstetrics and Gynecology, Emergency Room, et al. Almost all physicians and the majority of hospital personnel are aware of the many hours which the operating room nurse contributes to sterile pro-



FIG. 2. *Separate toilet facilities in cubicle.*

cedures. The preparation of the sterile instruments and sterile packs and the incessant drills in sterile technique clearly indicate the contribution made by nursing to infection control. Similar procedures are carried out in other areas of the hospital by the nursing staff. One does not need to go all the way back to Florence Nightingale to point out how nursing has influenced the cleanliness of hospitals. The endless contribution of this profession to this cause speaks for itself and needs little elaboration. Emergency Room, Intensive Care Unit, Surgery, X-Ray, Obstetrics, Physical Therapy, and Inhalation Therapy all have specially written infection control procedures.

What may not be so apparent are the measures which should be taken to insure that the personnel do not serve as a source of cross infection. A nasal culture is taken monthly from each employee who is employed in strategic areas such as the Operating Room, Nursery, and the Delivery Room. As in the Dietary Department, rigid procedures must be taken to prevent the incidence of cross infection by Surgery personnel.

By the same token, measures must be taken to protect hospital personnel. Nursing personnel have a higher incidence of exposure to infectious diseases than any other group in the hospital. One of the purposes of isolating patients with infectious disease, therefore, is to protect hospital personnel. The nursing personnel who are taught the procedures of isolation technique protect not only other patients, but also themselves.

Maintenance Department:

One infection control problem facing almost every hospital of multiple-story structure is the control

of contamination in the laundry chutes. The problem of cleaning and decontaminating this area is mammoth, but the Maintenance Department has provided our institution with an ingenious solution. A mechanical device has been developed to aid in this procedure thus reducing an almost impossible task to a rather routine performance. Our limited knowledge of mechanical devices is not adequate to describe this device here. We will therefore limit our discussion of this equipment to a mere mention of it and refer all inquiries regarding its operation to the Building and Grounds Department of Grant Hospital.

The Maintenance Department makes other contributions to the overall effort of cross infection control because no idea or suggestion of the Infection Committee regarding construction can be implemented without this department reviewing it and offering the necessary aid and comments. This, of course, adds only another example to the long list of those obviating the necessity of interdepartmental cooperation in controlling cross infection in hospitals.

Housekeeping:

The rigid procedures prescribed by this department for their personnel are most certainly conducive to an effective infection control. Cleansing agents and disinfectant agents must be specified and the amounts to be used easily measured and checked. The personnel are thoroughly indoctrinated in isolation procedures. When a patient is discharged, the room is cleaned with utmost care before another patient is admitted. Routine cleaning of patient rooms includes

complete change of dust cloths, cleansing solution, etc. before proceeding to the next room. Procedures are constantly reviewed with personnel so as to keep them thoroughly familiar with them. The Executive Housekeeper, working with the Infection Committee and the Purchasing Department, carefully chooses a phenolic disinfectant agent. He spends a good per cent of his time making sure that his personnel know how to use it. The Inspecting Officer of the hospital checks the work of this department weekly while checking the housekeeping practices of other departments. If any one department can be referred to as the key department in infection control, Housekeeping is the one.

The Laundry:

The Laundry contributes to infection control through the proper treatment of hospital linen and special procedures established for handling contaminated linen. All isolation linen is placed in water soluble bags. These bags are then placed in self-closing laundry bags before they are placed in the laundry chute. When this linen reaches the Laundry, it is washed separately from other linens. The entire water soluble bag is taken from the outer bag and placed in the washing machine. Additional quantities of detergent and bacteriostatics are placed in this wash. Periodically, cultures are taken to test the effectiveness of these procedures.

Care must be exercised in selecting linen so as to prevent the use of fabrics, which may not readily lend themselves to effective disinfection processes. For example, cotton-thermal blankets are used in lieu of blankets made of other materials, which may not be so easily washed and decontaminated as the cotton.

The linen shelves and carts are cleaned with detergent and disinfectant solutions. Periodically, these shelves are cultured to again verify the cleanliness of the area and the effectiveness of the washing and decontaminating procedures.

Routine Inspections:

Effective control of infection within the hospital must necessarily include control measures in all departments. Almost every department and almost every employee is a source of contamination or in some way affects the sanitation control in a manner that could ultimately reach the patient. All departments and personnel must therefore be liable for inspection. The hospital conducts a weekly inspection of selected departments. The inspection is made by a person who is not a hospital employee and can therefore be objective in all areas of the institution. The inspection is conducted primarily to detect plans in the overall housekeeping of all departments and includes results of duties performed by the Housekeeping Department and those performed by the individual department.

The department to be inspected on a given day is selected upon arrival of the inspecting officer. The inspecting officer is always accompanied by the Housekeeping Department and a representative from the department undergoing inspection, who is usually the department head. Having these persons accompany him enables the inspecting officer to communicate directly with the individual who is responsible for the deficiency he may find on his tour.

A report of the inspecting officer's findings is sent to the hospital administrator, to the department involved, and to the Infection Committee Coordinator. The Coordinator will follow up any report of deficiencies and see that proper measures are taken to correct them, if a threat to infection control is imminent.

The Infection Control Coordinator must be objective in her procedures and findings and should also have the authority to culture wherever she deems it advisable. No department should be immune to inspection and culturing.

Special Procedures

Special procedures must be written for many tasks performed in preventing the spread of infection; but for the purpose of this presentation, we shall limit the discussion of special procedures to those tasks that are not likely to be discussed in connection with a specific department or that may, for some other reason, be difficult to classify.

Cubicle Isolation:

Cubicle isolation is a technique used to isolate multiple infectious cases in one room. At Grant Hospital a plexiglas partition separates the areas occupied by the individual patients (Fig. 1). Each patient is provided with his own facilities, such as wash basin and toilet, so as to prevent cross contamination (Fig. 2). All contact between patients must be discontinued and all common facilities must be eliminated. Nursing personnel and other hospital personnel must utilize the same technique in going from one patient to another in cubicle isolation as is utilized in going from one isolation room to another, including the changing of gowns, washing of hands, etc. Theoretically, all isolation cases should lend themselves to cubicle isolation, but popular opinion dictates that some cases which are highly contagious should not be treated in cubicle isolation, e.g., tuberculosis. Grant Hospital Infection Committee is in accord with the practice of private room isolation for such cases.

Personnel utilizing the technique must be specially trained and procedures must be reviewed frequently.

Transporting the Isolation Patient:

Care must be exercised in transporting infection cases to other points in the hospital in order to prevent the spread of infection. The patient is placed on a litter and covered with a clean sheet. In cases of upper respiratory infections, the patient is required

to wear a mask. Personnel placing the patient on the litter must wear a gown and discard it before leaving the patient's room. Each area of the hospital where the patient is treated, e. g., Physical Medicine, has written procedures to follow during and immediately following the patient's visit. Equipment is thoroughly cleansed and disinfected using germicides approved by the Infection Committee before other patients are treated using the same equipment. These, like all other equipment, are cultured periodically to verify the effectiveness of the cleansing procedures.

When the patient is returned to his room, the litter must be decontaminated with germicides known to be effective against the organism causing the infection.

Conclusion

As a result of intense activity and close attention to detailed techniques, Grant Hospital has been able to reduce cross infection to a bare minimum. A surprising number of hours have been devoted to establishing a protective care unit, writing procedures for isolation techniques, and selecting effective germicidal agents. Many people from several areas of hospital practice have been involved and have contributed to the body of information we now possess. The end product has been an increase in confidence of the Medical Staff that Grant Hospital is a safer place for patients to be treated in that cross infection is drastically reduced.

Eliminating cross infection is a noble goal, but extremely difficult to obtain. Care must be exercised in establishing procedures. Procedures directing too little care are almost as bad as having none at all. It is easy, however, to set up procedures which are impractical and cause needless overlap in effort, and a serious waste of hospital personnel time. One must

therefore use sober and sound judgment in establishing policies and techniques so as to obtain the desired results.

The hospital has an obligation to its patients to contribute everything it can in order to speed their recovery. It has an equal, if not greater, obligation to see that it does not harm the patient. In this respect, good infection control procedures are not only worth the effort of establishing them but are necessary for proper patient care. Establishing good procedures is only a part of the job. Someone must keep the vigilance to see that the policies and procedures set forth by the Infection Committee are clearly understood and are being carried out. The Infection Committee Coordinator must make regular visits to key areas of the hospital and develop a keen eye for detecting breaks in isolation techniques. The Infection Committee at Grant Hospital is convinced that with planning, personnel training and cooperation, written procedures and faithful vigilance, effective control of hospital infections can be obtained.

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MEDICAL EDUCATION AND PRACTICE. — The undergraduate period is the beginning of medical education; its task is to lay the foundation of further education, both graduate and postgraduate, and to prepare students for practice under supervision. The foundation is a rational understanding of mental and physical disease, and of the methods of identifying them in individuals with a view to treatment and prevention. New therapeutic opportunities will demand even higher technical standards in the future, and the problem will be to achieve them while ensuring that education remains as humane as I believe it does to-day. Without such a foundation doctors will be merely purveyors of welfare. With it they can learn to practise efficiently according to their temperament and their personal beliefs. Some will envelop their patients in a benevolent paternalism, others will pursue a philosopher's stone for positive health and universal prevention, but many will be content to practise medicine well, and perhaps, as Parkinson has said, "will accompany their patients on the second mile, and to the end of the road." — Alastair Hunter, M. D., F. R. C. P., London, England: *British Medical Journal*, 2:552-557, September 4, 1965.

Surgical Scrub Degerming

The Effect of Personal Bar Soaps

ELMER A. BANNAN, M.S.

REGULAR and exclusive use of a sanitizer soap containing bacteristatic agents results in a reduction of viable bacteria on the hands.^{1,2} Furthermore, Weatherall³ demonstrated that the intermittent use of a hexachlorophene soap had no effect in reducing the number of superficial bacteria on the hands.³ These reports support the advocates, Lowbury,⁴ Walter,⁵ and Price,⁶ for exclusive use of a sanitizer product for skin care of surgical staff personnel. However, surgical staff personnel do not generally realize how much the use of an effective sanitizer soap for personal hygiene will contribute to reducing the level of bacteria on their hands during surgery.

This study was undertaken to demonstrate the magnitude of the effect that exclusive use of a sanitizer soap bar can have in reducing the number of bacteria found on the hands of the surgical staff at the completion of surgery.

Rationale of Experiment

Subjects were surgeons and surgical scrub nurses from the General Surgery Service of a large private hospital.* Since the test subjects were reluctant to use skin cleansing products without antibacterial additives for surgical scrubbing (because of the concern about possible risk of postoperative infection), a double-blind study using a nonsanitizer soap product as a control was not feasible. Moreover, the individuals were hesitant to change from their customary scrub products until the effectiveness of the test product had been demonstrated to them.

An experimental design was developed to take these restrictions into account. The test program involved three sequential phases. The initial phase consisted of monitoring of each subject's hands to establish the base level of bacteria corresponding to his customary usage of scrub and other skin cleansing products. In the second phase, the sanitizer bar soap** was used exclusively by the subjects for their

The Author

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personal hygiene (at office and at home) while they continued to scrub with their customary surgical products. In the final phase, the surgeons and the surgical scrub nurses used the sanitizer bar soap exclusively for surgical scrubbing as well as for all nonscrub skin cleansing. Because of the known variability in the numbers of bacteria on the skin among individuals, a relatively large number of samples (ranging from 6 to 29 with a mean of 13) was obtained from each subject in any period before he was considered eligible for the succeeding phase.

Materials and Methods

The design of the bacteriologic test was similar to that described by Lowbury.⁴ Samples were taken at the end of the operation, immediately upon removal of gloves. The hands were moistened in a basin containing 1 liter of tap water. A lather was "worked up" on the hands with a nonsanitizer bar soap for 30 seconds. The hands and wrists were then washed by working the lather over them for 60 seconds, making sure that all the washing residues dropped into the basin. Finally, the hands were rinsed in the basin of water for 30 seconds. The contents of the basin were mixed and two (1.0 ml) samples of the wash water were individually diluted with approximately 30 ml water and poured through sterile membrane filters. Membrane filters were immediately placed in a sterile petri plate containing absorbent pads saturated with Trypticase Soy Broth (BBL). Plate counts were made after incubation aerobically at 37°C. for 48 hours. Appropriate control experiments were performed to determine the possible influence of sanitizer carry-over effects and of the bacterial content of the tap water. Neither was found to have an appreciable effect on the test

Submitted July 21, 1967.

*Christ Hospital, Cincinnati, Ohio.

**A bar soap containing 3,5-di- and 3,4',5-tribromosalicylanilides, 4,4'-dichloro-3-trifluoromethyl carbanilide, and 3,4,4'-trichlorocarbanilide.

TABLE 1. *The Skin Degerming Effect of a Sanitizer Bar Soap—Operating Room Personnel*

Test Period	Product Assignment	Number Samples*	Total Aerobic Bacterial Level	
			Average Number Bacteria/ml**	Average Log Number Bacteria/ml***
1	None (Customary Products)	164	259	5.55
2	Sanitizer Bar Soap for Personal Hygiene only	164	86	4.46
3	Sanitizer Bar Soap for Personal and surgical scrub	133	22	3.07

*Total number of samples taken from 12 subjects during the indicated test period.

**Geometric mean; multiply by 1,000 for total number removed from both hands by single handwashing immediately following removal of gloves at end of operation.

***Analysis of variance performed on log transformation of individual counts. Least significant difference, LSD ($P < 0.05$) = 0.55) Log₁₀.

results. Bacterial counts were normalized by transformation to logarithms prior to statistical treatment (Analysis of Variance).

One membrane filter was used to inoculate a selective medium (Vogel-Johnson agar, Baltimore Biological Laboratories), for the differentiation of *Staphylococcus aureus*. After a 24-hour incubation, individual colonies were removed and confirmed to be *S. aureus* by the DNAase test (Di Salvo,⁷ Baltimore Biological Laboratories) and microscopic examinations.

Results

The results of the quantitative bacteriologic sampling (total aerobes) of the hands are summarized

in Table 1. Figure 1 shows the average bacterial level (based on log mean) for each of the individual surgeons and surgical scrub nurses for each of the three phases of the study. During both phases in which the sanitizer soap bar was used either for personal hygiene only or for all skin cleansing including surgical scrubbing, the subjects showed a decrease of bacteria on the hands. Before the assignment of the sanitizer bar for personal hygiene only, the average number of bacteria removed from both hands immediately after surgery was 259,000. The use of the sanitizer bar soap for personal hygiene resulted in a drop of 67 per cent

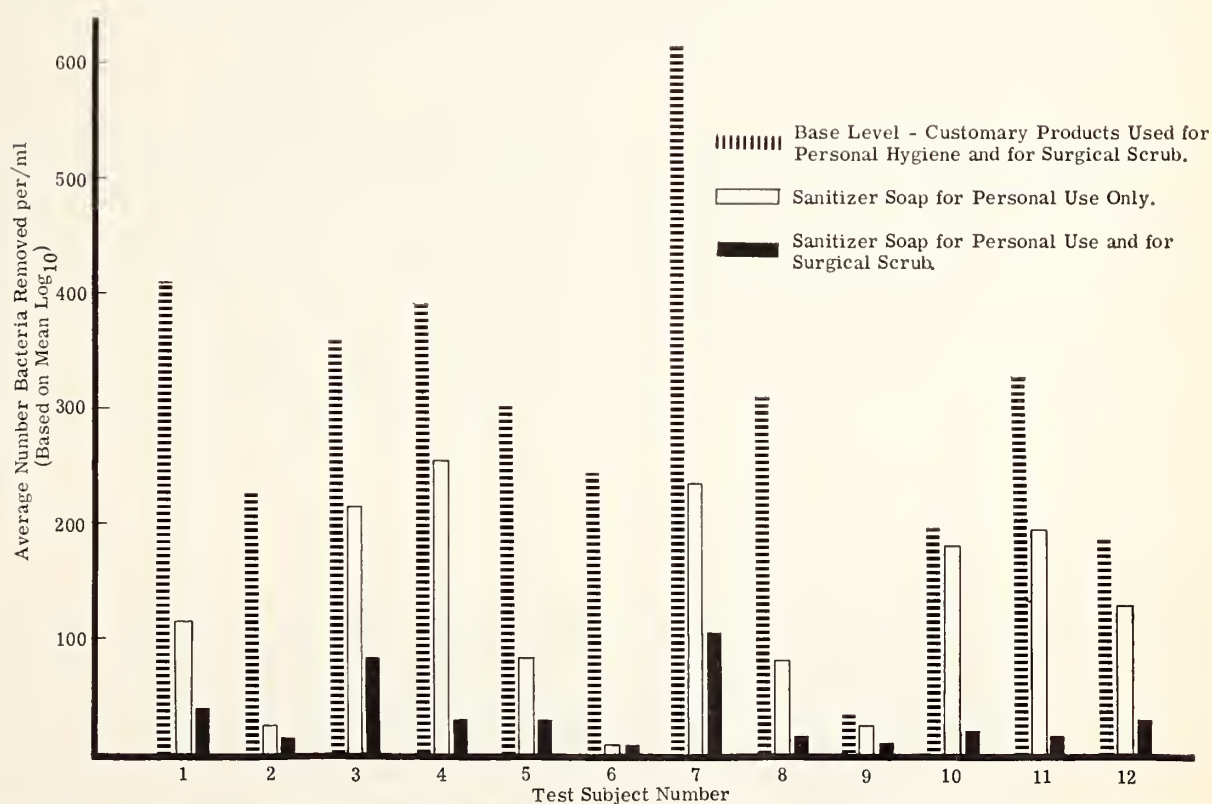


FIG. 1. *The effect of usage of a sanitizer bar soap on the levels of aerobic bacteria on the hands of surgeons and surgical technicians. (Hands washed immediately after removal of gloves at end of operation.)*

to an average of 86,000 organisms. When using the sanitizer bar for all their skin care, including surgical scrubbing, the subjects showed a further decrease in bacterial levels on the hands (Fig. 1). The average number of bacteria found was 22,000, a reduction of 91.5 per cent from the base level. Average numbers of bacteria on the hands of the subjects in each sequential phase of the study were significantly lower than in the preceding phase ($P < 0.05$).

The incidence of *S. aureus* on the hands in the initial phase of the study was found to be 14 per cent (Table 2). A decrease in the incidence (to 9 per cent) of pathogenic *S. aureus* was observed dur-

TABLE 2. *The Effect of a Sanitizer Bar Soap on the Incidence of Staphylococcus aureus on the Hands of Operating Room Personnel*

Test Period	Number Samples*	Number Positive <i>S. aureus</i>	<i>S. aureus</i> Incidence (%)
1	149	21	14%
2	166	15	9%
3	134	4	3%

*Total number of samples taken from the 12 subjects during the test period.

ing the use of the sanitizer product for personal hygiene only. The incidence was further reduced to 3 per cent when the sanitizer product was used for all skin care.

Comments

The study was designed to use bacterial levels at the end of surgery as an index of skin degerming effectiveness. This level at the end of surgery represents a bacterial accumulation which, if large, could be a source of contamination in the event of a glove puncture or tear. Incidentally, we noted that 18 per cent of our surgeons' glove pairs were punctured (67 punctured in 375 pairs examined).

Since the study was designed to reflect normal practices, with the exception of introduction of the

sanitizer bar soap for, first, personal use and then for exclusive use, no changes were prescribed for either scrubbing or personal washing procedures. The bacterial values of the base, or initial test phase (Table 1) are a representation of the degree of degerming ordinarily achieved by the 12 test subjects. During this phase, prior to the assignment of the test product, the subjects used products designed specifically for surgical scrubbing (liquids and/or bar soaps). A variety of commercial bar soaps were used at home. The downward trend (Fig. 1) of the bacterial counts, as the surgeons and scrub nurses progressed through the final two phases of the study program, demonstrates the importance of a sanitizer soap for personal hygiene in reducing the bacterial flora of the hands. The results of this study support the observations of earlier investigators that it is possible to achieve a very low level of skin bacterial flora by the daily exclusive use of a soap containing antibacterial additives.

Summary

A bar soap containing antibacterial additives, when used for personal hygiene can act as a significant adjunct to surgical scrub procedures in reducing bacterial levels. Exclusive use of the sanitizer bar soap for both personal hygiene and for surgical scrubbing resulted in a further reduction of the bacterial flora of the hands.

Acknowledgments: The author wishes to express his appreciation to the surgical staff of Christ Hospital and to Miss Joan Amareno, for her technical assistance.

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POTENTIATION OF ANTICOAGULANT.—Equilibrium-dialysis experiments showed that phenylbutazone displaced warfarin from human serum albumin binding in vitro. It is suggested that phenylbutazone potentiates the action of warfarin in vivo by displacing warfarin from its binding to plasma albumin, making increased quantities of free drug available both to drug metabolizing enzymes and to specific sites of biologic action in the liver.—Paul M. Aggeler, M.D., Robert A. O'Reilly, M.D., et al., San Francisco: *The New England Journal of Medicine*. 276:496-501, March 2, 1967.

Staphylococcal Septicemia

A Study of One Hundred Cases

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THIS is a study of 100 cases of staphylococcal septicemia occurring at Akron General Hospital from July 1962 through December 1965. During this time period, hospital admissions averaged 14,380 per year. These 100 cases represent all those occurring during that time period, with the exception of six cases excluded because no sensitivity studies were performed. All were antemortem cultures. During that period of time, there were 32 streptococcal septicemias, 24 pneumococcal, 17 *Bacillus subtilis*, and 14 other gram-positive septicemias. In contrast, gram-negative septicemia averaged 54¹ cases per year.

This study will examine the differences between *Staphylococcus albus* (coagulase-negative) and *Staphylococcus aureus* (coagulase-positive) cases with regard to incidence, age, portal of entry, associated factors, sensitivity studies, presence of a diagnostic clinical syndrome, and mortality. Special attention will be paid to the septic shock group with regard to diagnosis, treatment, and outcome.

Results

There were 68 cases of *S. albus* sepsis, and 32 of *S. aureus*. The average age of the former was 56 years, the latter 58. There was no preponderance of either sex. There were seven cases of mixed septi-

TABLE 1. Portal of Entry

Cases <i>S. albus</i>	Portal of Entry	Cases <i>S. aureus</i>
26	Respiratory of Tract	12
11	Urinary Tract	3
2	Skin	7
5	Gastrointestinal Tract	1
3	Liver — Biliary	1
2	Vascular Catheter	0
3	Miscellaneous	1
16	Unknown	7
68		32

cemia. There were two each of *S. aureus* and *Proteus*, *S. albus* and *B. subtilis*, *S. albus* and *Bacteroides*, and one of *S. aureus* and *Diphtheroids*. Hochstein² noted a 7.8 per cent incidence of multiple organism septicemias in over 17,000 cultures, with *S. aureus* plus *Escherichia coli* being the most common combination.

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The respiratory tract was found to be the most common portal of entry, followed by urinary tract, skin, etc.

Arteriosclerotic heart disease was found in a total of 19 cases, being the most common associated disease. Diabetes mellitus was present in 18 cases. Malignant tumors and presepticemia steroids and

TABLE 2. Factors Associated with Septicemia

Cases <i>S. albus</i>	Associated Factors	Cases <i>S. aureus</i>
13	Heart Disease (ASHD)	6
12	Diabetes Mellitus	6
5	Cancer	5
3	Outpatient Steroids	2
2	Outpatient Antibiotics	2
3	Chronic Liver Disease	1
4	Nonmalignant Hematologic Disease	0
2	Chronic Renal Disease	1
2	Malignant Hematologic Disease	0

antibiotics were frequently associated. Liver, renal and hematologic disease were also seen in a few cases.

The sensitivity studies were performed using the disc method. There was a high incidence of tetracycline resistance—32 per cent of *S. albus* and 56 per cent of *S. aureus*. Resistance to penicillin G was demonstrated in 16 per cent of *S. albus* cases, and in 75 per cent of *S. aureus*! Resistance to chloramphenicol was 9 per cent and 16 per cent, respectively, with most of these occurring in the cases in the last year of the study. The semisynthetic penicillins (methicillin, oxacillin, and even ampicillin) were nearly

¹From the Division of Surgery, Akron General Hospital, Akron, Ohio. Submitted June 8, 1967.

always effective in the laboratory, as was erythromycin. It has been extremely rare in this Hospital to find staphylococci resistant to lincomycin.

TABLE 3. *Sensitivity Studies — Resistant Organisms*

SENSITIVITY STUDIES — RESISTANT ORGANISMS		
S. albus	Drugs	S. aureus
16%	Penicillin	75%
32%	Tetracycline	56%
9%	Chloramphenicol	16%
1%	Erythromycin	6%
1%	Ampicillin	9%
1%	Oxacillin	0%
0%	Methicillin	0%
1%	Lincomycin	0%

There has been no general consensus that gram-positive organisms cause a clinical syndrome similar to endotoxin shock; however, the rigid distinction between exotoxins and endotoxins is now questionable. Skinner³ showed that staphylococcal toxin in low concentrations acts selectively on the kidney without systemic blood pressure changes. The toxin he used had properties of both exotoxin and endotoxin. We examined our patients' records carefully for symptoms and signs characteristic of septicemia. If a patient had chills, fever, and mental aberration, plus any two of the following—myalgias, nausea, vomiting, oliguria, warm dry skin or slow bounding pulse—we felt he manifested the typical clinical syndrome. It was found that 29 per cent of the 68 *S. albus* cases and 44 per cent of the 32 *S. aureus* cases had this clinical picture. Half of the 38-patient septic shock group had this picture.

Septic Shock Group Results

A special consideration of this group of 38 patients is indicated to examine the role of coagulase-negative staphylococci in the production of septic shock, and to draw conclusions regarding treatment.

There were 25 cases of *S. albus* and 13 of *S. aureus*. Sixteen of the former died, while 11 of the latter died. The average age of the *S. albus* group was 58, of the *S. aureus*, 67. There were no neonates. Males predominated in both groups slightly more than two to one. The portals of entry were in nearly the same proportions as in the total group (see Table 1). There were differences in associated diseases. Only two were diabetic. Chronic hepatic and renal diseases were more common, as were steroid treatment (presepticemia) and malignancy. (The latter totaled six.)

Resistance to antibiotics, as indicated by the disc sensitivity studies, were twice as common as in the nonshock group, but there were no differences related to individual drugs.

As in septic shock due to gram-negative organisms early diagnosis and treatment are imperative if sur-

vival is to be common. Of the 38 patients, only one whose treatment started later than one hour after blood culture was drawn survived!

Although the authors agree with current emphasis on treating the patients' hemodynamic problems,⁴⁻⁶ adequate antibiotic therapy remains a *sine qua non* for survival. In Table 4, it is noted that the most serious error with regard to treatment is delay in starting antibiotics. For tabulation, this is defined as waiting two hours after culturing the blood to start antibiotics.

TABLE 4. *Results of Antibiotic Treatment*

ANTIBIOTIC TREATMENT — SHOCK GROUP		
	Lived	Died
Adequate	10	11
Inadequate	0	
Amount	0	4
Time	0	9
Amount and Time	0	5

Steroids were used in massive amounts in only six of the 21 patients adequately treated with antibiotics. Four survived. The number of patients is obviously too small to warrant any conclusions regarding their efficacy.

Vasopressors were frequently used. Favorable response to vasopressors alone was uncommon. The most commonly used agent was metaraminol.

Making the Diagnosis

In most cases of *S. aureus* septic shock, a progression of symptoms and signs similar to that of gram-negative septic shock⁷ is seen. In the first stage of septic shock, the pulse is slow, the skin hot and dry, and the blood pressure not much depressed. The clue to diagnosis is the patient's confusion. Both Udhoji⁸ and MacLean⁹ found that these patients have a high cardiac index, a low peripheral resistance, and are alkalotic and hypoxic. Distribution of blood flow is apparently abnormal. Most of these patients can be saved.

In the second stage, the skin becomes cold and clammy, the pulse increases and oliguria ensues. These patients have been found^{4,5} to have low cardiac indices, high peripheral resistances, lactic acidemia, oliguria, hypoxia, and hypotension.

Discussion

Importance of S. albus:

One of the principal aims of this study was to evaluate the significance of a *S. albus* bacteremia. Of the 68, only eight were of unknown portal of entry, sensitive to all antibiotics, and were not associated with the signs and symptoms of septicemia. These may well have been skin contaminants, not related to the basic disease process. Twenty-five of the 68 were in septic shock and 16 died, of whom 29 per cent were felt to have the signs and symptoms of septicemia.

Antibiotic Therapy:

Certain conclusions regarding antibiotic therapy seem pertinent. If penicillin is used, it must be used in large doses to overcome resistance. All of our patients receiving less than 5,000,000 units daily died. Second, the high incidence of tetracycline resistance would seem to argue against the initial use of this drug. We noted with interest a significant percentage of resistance to chloramphenicol. The commonly used combination of penicillin and chloramphenicol may fail in many cases.

It seems wise to administer one of the semisynthetic penicillins initially, along with penicillin G, since resistance to the former has been uncommon to date. Cephalothin has also been used by the authors with success, particularly in cases where the etiologic organism is not yet known to be *Staphylococcus* rather than gram-negative.

Controversies in Drug Therapy of Shock:

Until the antibiotics (and indicated surgery) can eradicate the blood-stream infection and its source, drug therapy must be employed to maintain adequate tissue perfusion.

MacLean⁴⁻⁹ has emphasized a hemodynamic approach, stressing that patients in shock from several causes manifest cardiac failure. Central venous pressure (CVP) monitoring is mandatory. If the CVP is low, colloid is given usually in the form of whole blood. If the response to volume replacement is poor, isoproterenol (1 mg. in 500 ml. dextrose in water) is given. This drug has several pharmacologic advantages for treatment of shock.⁴⁻⁶ Its positive inotropic properties lead to an increase in cardiac output. Wilson¹⁰ correlated cardiac output with survival. It causes peripheral vasodilation, which decreases peripheral resistance. The latter coupled with increased cardiac output gives improved tissue perfusion. Urinary output increases. Coronary perfusion is increased. Pulmonary vascular resistance is lowered.¹¹ This is important because endotoxin causes increased pulmonary artery pressure,⁶ and pulmonary edema may occur when CVP is normal.⁵ Metaraminol has been reported to possess inotropic properties. Most studies comparing the two do not show a significant increase in cardiac output with metaraminol or norepinephrine.⁴⁻⁶ Our most recent clinical experience has led us to favor Isuprel®.

Adrenal corticosteroids have been used with increasing frequency in the treatment of shock. Studies reported have shown a lowering of peripheral resistance,¹² an increase in cardiac output,¹²⁻¹⁴ and restoration of normal relationship between arteriolar and venular sphincters in the peripheral circulation.¹³ While they have been reported to increase survival

in gram-negative shock,¹⁻⁷ there have been no data demonstrating their efficacy in shock due to gram-positive organisms. Our data are again too small to be significant in this regard.

Summary

1. One hundred cases of staphylococcal septicemia occurring within a three and one-half year span are reviewed.
2. The 68 *S. albus* (coagulase-negative) cases are compared and contrasted with the 32 *S. aureus* (coagulase-positive) ones.
3. Data indicate *S. albus* septicemia is significant and should be vigorously treated.
4. Early diagnosis and prompt treatment are imperative for survival.
5. A high percentage of penicillin and tetracycline resistant organisms were recovered.
6. Early treatment with penicillin G plus a semisynthetic penicillin is recommended.
7. Controversial aspects of drug therapy in septic shock are discussed.

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Spatial Vectorcardiography

II. Methods of Obtaining. Graphic Construction from the Scalar Electrocardiogram

ROBERT T. MURNANE, M.D.*

PART I of this series dealt with background information required for proficiency with any method of vectorcardiography.

Part II will introduce methods of obtaining vectorcardiograms and review the present status of graphic construction from the scalar electrocardiogram.

Vectorcardiograms (VCGs) can be obtained by:

1. Graphic construction
 - a. Manual
 - b. Use of special instruments
2. Automatic recording
 - a. Special galvanometer
 - b. Cathode-ray oscilloscope

1. Graphic Construction

a. *Manual*: Hubert Mann (1920) originally used this method to introduce the idea of VCG. It consists of plotting several instantaneous axes from two or more ECG leads recorded simultaneously. This method was extended to the conventional 12-lead ECG by Robert P. Grant (1949).

b. *Use of special instruments*: Shillingford and Brigden (1951) described a "vector drawing machine" to locate simultaneous points on two ECG leads and indicated their resultant by a system of mirrors. Modified versions of the vector drawing machine have been proposed. These semiautomatic methods accomplish the same result as manual construction when the latter is carried out with simultaneously recorded scalar leads.

Disadvantages of Graphic Construction

1. Simultaneous ECG leads are essential. Leads not recorded coincidentally are subject to considerable error.
2. The number of simultaneous points which can be accurately identified on ECGs is limited. The detailed form of the VCG is therefore not recognizable.

3. Methods are laborious and time consuming.

The above graphic methods of construction from the ECG are specifically and correctly referred to as vectorelectrocardiography. The Grant method enjoys contemporary popularity. It has done much to advance the concept of vector analysis and has had application in clinical situations. However, there are some objections to its use.

Grant's system treats with the clinical ECG in which the leads are not recorded simultaneously. In addition, it does not consider the vector location of intervals of less than .04 sec. duration, and as originally proposed was limited largely to frontal-plane leads, right-left and superior-inferior. A technically excellent ECG can be analyzed at intervals as brief as .01 sec. (Part I of this article explains the importance of attention to vector intervals of briefer duration than .04 sec.)

A further objection to Grant's method is the need of 12 leads. Use of the scalar ECG requires only three nearly mutually perpendicular leads for vector analysis. The right-left lead V6, the superior-inferior lead aVf, and the anterior-posterior lead V1 serve this purpose. These leads are so connected to the galvanometer that when the first half of the P wave is observed to be upright on V6, it may be confidently deduced that it is directed leftward. When the same force simultaneously projects as an upright deflection on aVf, the interpreter knows that this force is directed inferiorly. Similarly, when this same force—the first half of the P wave—is upright on V1, it is directed anteriorly.

In summary, the three-dimensional, spatial locations are left, inferior, and anterior; this is the normal location for that portion of the P wave which is determined predominantly by right atrial depolarization. All ECG deflections can be similarly dissected into their clinically useful segments and their spatial locations determined from these three leads, which are approximately mutually perpendicular. V1, being to the right of the midline, is not a true anterior-posterior lead; V2 has similar limitations, being to the left of the midline. In addition, these scalar leads are uncorrected, having no electrical resistances

The Heart Page is a periodic feature of *The Journal* containing brief, practical comments on subjects of immediate importance to practicing physicians. The comments are solicited by the Professional Education Committee of the Ohio State Heart Association.—Ed.

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to balance them for their variable distances from the heart.

The newer orthogonal three-lead systems used for scalar leads, as for computer use and for recording of oscilloscopic loops, are at right angles to each other, the electrode axes all crossing near the theoretical electric center of the heart. In addition they employ ordinary electrical resistors to correct the inequalities of distance from the heart of the surface electrodes. All these provisions have been employed to restrict the range of normal values, thereby reducing the biologic data overlap between the normal and abnormal.

From the foregoing it may be apparent that the 12 leads of the clinical ECG are a mid-twentieth

century convention which makes a convenient albeit not continuous rhythm strip. They are neither corrected nor orthogonal, whereas three mutually perpendicular corrected orthogonal leads, by reason of their limited number and restricted range of normal values, lend facility to programming of, interpretation by, and read-out from a computer.

Part III of this series will consider the automatic recording of VCGs with emphasis on use of the oscilloscope, and the advantages and disadvantages of loop versus scalar presentations.

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The Project in Oscilloscopic Spatial Vectorcardiography has been supported by grants from The Central Ohio Heart Association.

TEENAGE DISC SYNDROME.—A child is not a miniature adult and special rules must be applied in evaluating his backache. The diagnosis of herniated nucleus pulposus in a teenage patient requires alertness to this possibility and a high index of suspicion for the condition. Facts to be found in the history are negative in that no definite injury may be reported, and back pain as well as leg pain do not attract the parent's attention for need of an examination.

Signs rather than symptoms provide the basis for establishing the diagnosis. If one considers the mild to moderately severe cases as bona fide instances of teenage disc disease the condition is common rather than rare. It may, however, be diagnosed infrequently and this would account for a lack of its inclusion in the general consideration of low back pain in children. In addition to the predominance of objective signs instead of subjective symptoms, there are other unique facts pertinent to the diagnosis and treatment of the teenage disc syndrome. Whereas x-ray studies are usually most helpful and often specifically conclusive in establishing a disease process in a child complaining of backache, they are significantly lacking in help towards confirming the diagnosis of a ruptured disc at the teen level.

Presenting symptoms are most commonly confined to an inability to bend forward but occasionally this can be a loss of extension. An abnormal gait or change in appearance from running to walking is often noticed. The straight leg raising signs are almost always positive at high degrees of extension and, unless the protrusion is central, there is a negative well leg raising sign. The sensory and reflex changes so universally found in adults are absent. Weakness of the toe is not observed. Atrophy is almost never present. Pain on deep pressure over the pathologic disc or discs is present at varying degrees of severity.

Whereas previous reports of teenage disc cases have indicated a high degree of success with conservative treatment, our experience has been the opposite. Surgical excision of the offending disc or discs has resulted in a higher percentage of recovery than that found in even the most favorable reports of surgical treatment of the condition in adults.—P. L. Day, M.D., San Antonio, Texas: *Southern Medical Journal*, 60:247-250, March 1967.

Electrocardiographic-Pathologic Conference

Combined Ventricular Hypertrophy

RALPH C. SCOTT, M.D.*

THE FORMAT of the electrocardiographic-pathologic conference (EPC) was outlined in the first article in this series.¹

Electrocardiographic Interpretation

The tracing recorded on August 10, 1959 is shown in Fig. 1. There are deep S waves in the right precordial leads ($SV_1 = 28$ mm.; $SV_2 = 45$ mm.). Tall R waves are seen in V_5 (43 mm.). The T waves are deeply inverted in V_3 and V_4 and to a lesser extent in V_1 and V_2 , suggesting antero-septal ischemia. The P waves are abnormal. There is wandering of the pacemaker and intermittent AV dissociation.

A tracing recorded on October 12, 1960 is not illustrated. The S wave in V_2 is approximately 35 mm. but the S wave in V_1 is only 7 mm. The T waves are upright in the right precordial leads. Left ventricular hypertrophy (LVH) is obviously present; however, with shallow S waves in V_1 one might speculate that early right ventricular hypertrophy (RVH) may be emerging.

In Fig. 2 is the electrocardiogram recorded on February 15, 1965. Abnormal right axis deviation (RAD) of $+120^\circ$ is present. A premature ventricular contraction is noted in lead aVR. The S waves

now measure only 2-3 mm. in V_1 and 29 mm. in V_2 ; the R waves are low in the left precordial leads (8 mm. in V_6). There is no Q wave in V_6 . The P waves are diphasic in V_1 , the total amplitude measuring nearly 5 mm. These changes from the earlier tracings would strongly suggest combined ventricular hypertrophy (CVH) and biatrial enlargement. Incomplete left bundle branch block is also present.

Clinical Resumé

This 63 year old Negro man was asymptomatic until 1956 when he noted the onset of mild dyspnea on exertion. He subsequently had many emergency room, outpatient clinic, and hospital visits at the Cincinnati General Hospital for congestive heart failure.

In 1959 he was admitted to the hospital and found to have signs of pulmonary emphysema as well as cardiomegaly, hepatomegaly and peripheral edema. There was some evidence that pulmonary embolization may have complicated that admission. Subsequently, the patient failed to keep regular clinic appointments or to take his medications.

In March 1963 he was restarted on digitalis and diuretics because of severe dyspnea and gross pitting edema of the lower extremities. The patient lost 10 lbs. with marked symptomatic improvement. From 1963 to 1965 his course was characterized by varying degrees of cardiac decompensation and evidence of chronic malnutrition.

His blood pressure readings were not consistently elevated but did reach a high of 150/120 when in congestive failure in 1959. After 1960 all recorded blood pressures were normal.

He was admitted to the hospital for the final time on February 15, 1965 and died three days later.

Necropsy Findings

At autopsy this 63 year old man was malnourished, weigh-

From the Cardiac Laboratory, Cincinnati General Hospital and the Department of Internal Medicine, University of Cincinnati College of Medicine, Cincinnati, Ohio. Submitted July 27, 1967.

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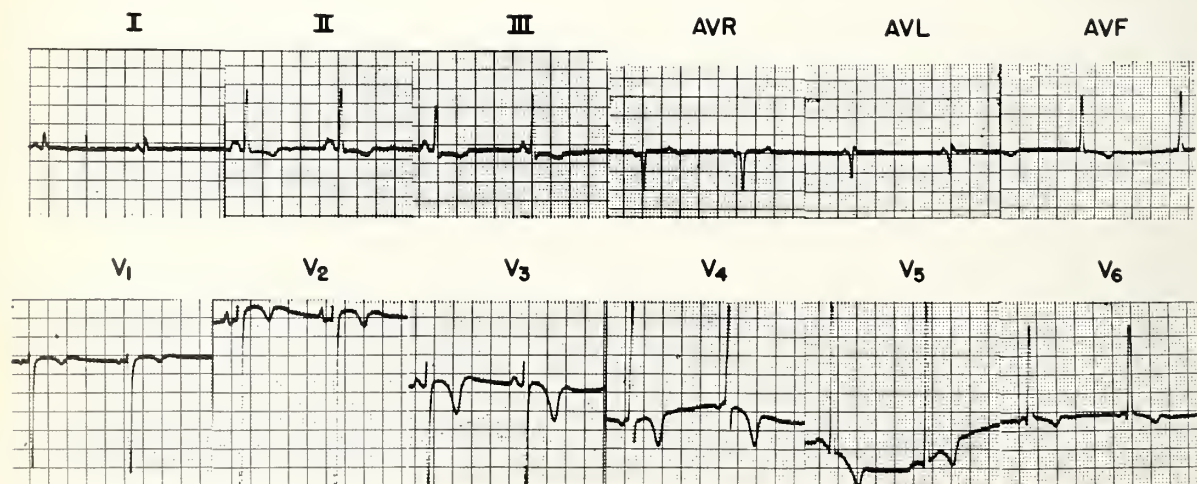


FIG. 1. This electrocardiogram recorded on 8/10/59 displays left ventricular hypertrophy and antero-septal ischemia.

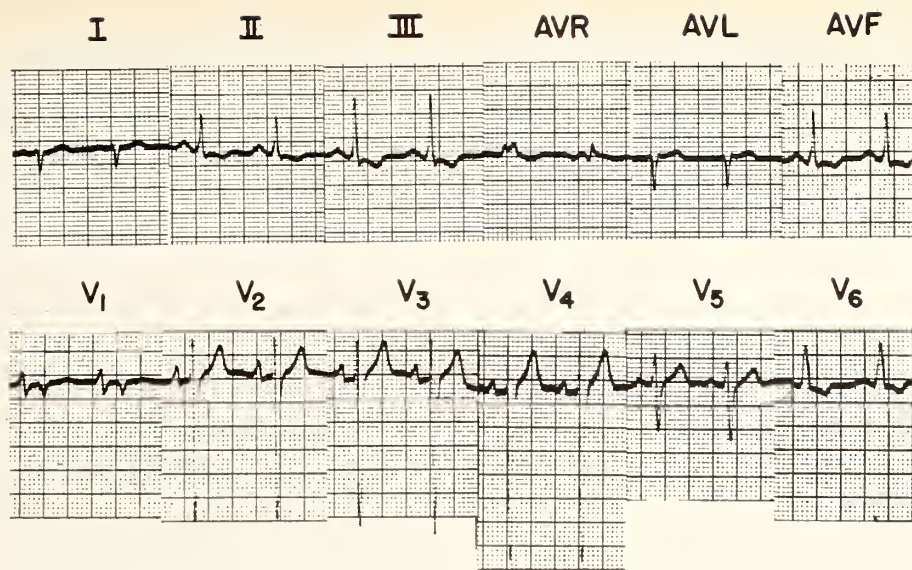


FIG. 2. This tracing recorded on 2/15/65 shows abnormal right axis deviation, biventricular hypertrophy, biatrial enlargement and incomplete left bundle branch block.

ing 108 lbs. and measuring 65 inches in length. The cause of death was cardiac failure.

The heart weighed 453 Gm. and after epicardial dissection, weighed 440 Gm.; it was hypertrophied according to the criteria of Zeek.² Moderate dilatation of both ventricles was observed. The weights of the left ventricle plus septum (LV + S) and right ventricle (RV) were 256 and 93 Gm., respectively, both considerably higher than the maximum normal values of 175 and 65 Gm. for a man of this stature.³ Organizing mural thrombosis was prominent over the endothelial surface of the dilated lateral left ventricular wall. The valves were normal. Minimal atherosclerosis was present in the coronary arteries, but despite this a healed myocardial scar measuring 4 by 5 by 5 cm. was present in the posteroseptal area. Elsewhere in the myocardium there was a moderate degree of fine interstitial fibrosis. Whether the scarring of the myocardium was ischemic or represented the residue of an old myocarditis could not be ascertained.

The lungs were the site of moderately severe hemorrhagic pulmonary edema. Occasional small pulmonary emboli undergoing organization were seen microscopically. There was no significant pulmonary emphysema.

Anatomic Diagnoses:

1. Combined ventricular hypertrophy.
2. Myocardial scarring, posteroseptal area.
3. Interstitial myocardial fibrosis, moderate.

Comments

This patient had no valvular lesions and no persistent hypertension. Although there was only very minimal atherosclerosis of the coronary arteries there was a large scar of the posteroseptal area.

The electrocardiographic tracings recorded over a five and one-half year period showed changes from a florid LVH pattern to one of CVH. The abnormal RAD and very shallow S waves in the right precordial leads (Fig. 2), developing in a patient with a

prior pattern of LVH (Fig. 1), is virtually diagnostic of CVH. The P wave changes were very striking and were highly suggestive of biatrial enlargement.

The precise anatomic explanation for the appearance of the RVH is not entirely clear. One may speculate that recurrent left heart failure resulted in right heart enlargement. The pulmonary emboli found on microscopic examination may also have contributed to the RVH. One may further speculate that the myocardial scarring may have been due to ischemia or to a healed myocarditis.

Myocarditis or primary myocardial disease must also be considered in differential diagnosis. It is well known that this condition may result in CVH and atrial enlargement.

Acknowledgments: The author wishes to express his thanks to Dr. Kevin E. Bove who performed the detailed necropsy examination in this case and to Dr. Robert J. Norris and Dr. Emmett Conyers for their participation in the electrocardiographic and clinical correlation.

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A Clinicopathological Conference

From The Ohio State University Hospital, Columbus, Ohio

Edited Under the Auspices of the Ohio Society of Pathologists

PAUL N. JOLLY, M.D., *President*

PRESENTATION OF CASE

A MULATTO woman, aged 47, entered The Ohio State University Hospital with the chief complaint of shortness of breath. She died 20 days later.

The patient had been in good health until six years prior to admission when she developed "nervousness." A physician told her that her blood pressure was low. Since then she had complained of leg cramps when climbing stairs, relieved only by rest. For the past several years she had noted intermittent dizziness after standing for long periods of time or when bending over quickly. This was relieved by lying down. One syncopal episode occurred about one year prior to admission. She was unconscious for a few moments and thereafter felt weak for several hours. She was hospitalized elsewhere but was told that she was overanxious and otherwise in good health. Later, dyspnea on exertion developed and gradually progressed until about one week prior to admission she was unable to breathe when lying flat in bed. She denied having hemoptysis, pedal edema, chest pain, phlebitis, or cough. The patient stated that she had "rheumatism" at age 12, manifested by painful, swollen knee joints, which persisted for two weeks. She was not seen by a physician and gradually the symptoms subsided.

The patient had had three pregnancies without complications. At the age of 27 she had a hysterectomy and appendectomy without complications. The past history was otherwise not remarkable. Both parents and all siblings were living and well.

Physical Examination

At the time of admission the patient was in no acute distress. The blood pressure was 130/110, pulse rate 102 per minute, respiratory rate 15 to 18 per min., temperature 100 F. The skin, head, eyes, ears, nose and throat were normal. There was no adenopathy, and the thyroid was not enlarged. The cervical veins were distended with the patient in sitting position. There was a small left parasternal heave. The first heart sound was quite loud and there was no opening snap. There was a grade III/VI holosystolic coarse murmur at the left lower ster-

Presented by

- Charles F. Wooley, M.D., Columbus, and
 - Francis E. Cuppage, M.D., Columbus:
- Edited by Emmerich von Haam, M.D.

nal border, intermittently honking, increasing with inspiration, and nonradiating. The second sound was slightly accentuated. There were also a grade III/IV high-pitched blowing holodiastolic murmur at the pulmonary area and a diastolic gallop of the third heart sound which disappeared when the patient's pulse rate fell from 110 to 90 per minute. One observer thought that he heard a pericardial friction rub at the base of the heart.

Examination of the lungs revealed bilateral basilar rales and dullness to percussion at the right base. The abdominal examination revealed no abnormalities; liver and spleen could not be palpated. The extremities showed no clubbing, edema, or cyanosis, and the pulses were normal. The neurologic findings were physiologic.

Laboratory Data

The admission blood count showed 5,800 leukocytes with a normal differential count. The hemoglobin was 12 Gm., the sedimentation rate 42 mm. A urinalysis showed 160 mg of protein per 100 ml and an occasional granular cast and 4 to 5 white blood cells per high power field. The blood urea nitrogen level was 12 mg, creatinine 1.1 mg, fasting blood sugar 55 mg/100 ml. The serum electrolyte values were normal. Alkaline phosphatase readings were 7 and 7.9 units. The serum electrophoresis showed 8.8 Gm. of total protein per 100 ml with 2.5 Gm. of albumin and 4 Gm. of gamma globulin. The cephalin flocculation test was 1 plus positive. A latex fixation test was positive 1:10,240. Antistreptolysin titer was negative. Cold agglutinins were positive in a titer of 1:4. Serologic tests for syphilis were nonreactive, as were tests of the urine for Bence Jones protein. The values obtained for bilirubin, calcium, phosphorus, cholesterol, and protein-bound

Submitted July 21, 1967.

iodine were normal. No pathogens were grown in cultures of urine, sputum, and blood.

An electrocardiogram showed a complete left bundle branch block. The chest x-ray film and cardiac fluoroscopy showed marked cardiomegaly with significant enlargement of the right atrium and the lungs appeared congested. An upper gastrointestinal series showed no abnormalities. A repeat examination of the chest showed a large heart with questionable mitral valve and intracardiac calcifications.

Hospital Course

Shortly after admission, treatment with ampicillin was begun for what was thought to be a pneumonic process in the right lung. The patient responded within 48 hours and remained afebrile. Digitalis was started for her congestive heart failure and the salt intake restricted. She lost 24 lbs. over the next two weeks. Her loud honking-type systolic and diastolic murmurs disappeared gradually as she lost weight, and her blood pressure fell to normal levels. A bone marrow examination was not diagnostic. Lupus erythematosus cells were not seen in the bone marrow. Elevations of the 7S globulins were found upon ultracentrifugation of the patient's blood.

The patient seemed to improve until about the 17th day, when atrial fibrillation was noted. A biopsy of the left calf was reported showing normal skin and muscle. In the afternoon after the biopsy the patient noted severe cramping pain in her abdomen which was associated with diaphoresis and a fever up to 101 F. She complained of pain in both lower extremities.

She then became more lethargic and her blood pressure fell slowly. Her urine output decreased to about 130 ml over an eight-hour period. She was given intravenous sodium bicarbonate and intravenous penicillin, and Aramine® was started. It was believed that the patient had developed a gram-negative sepsis. The white blood cell count rose to 22,000 with 90 per cent neutrophils. Rales developed in her lungs, and a loud gallop of the third heart sound was heard. Blood cultures produced no growth. However, white blood cells too numerous to count and gram-negative bacteria were seen in the urine. A day later the patient suffered cardiac arrest. Resuscitation was initially successful. A very rapid atrial fibrillation responded to electrical defibrillation. Streptomycin in high doses, steroids and Isuprel® were added to the regimen. Her temperature continued to climb slowly and her blood pressure fell. Her condition deteriorated steadily and she died.

CLINICAL DISCUSSION

DR. WOOLEY: Our case today is an extremely interesting one. I think it touches upon a number of areas of interest both for the clinician and the pathologist, and probably also for the individual who is interested in investigating clinical areas that have

not been adequately delineated. I would like to give you my own thumbnail sketch of the clinical problem and then try to look at several facets that perhaps may shed a little light on this particular case.

This patient was a young woman who had a six-year history described as nervousness. Many young women when they initially present with heart disease are told by doctors that they are nervous, particularly when a great deal of their clinical history relates to paroxysmal arrhythmias. She was also told of a low blood pressure, and this I think is of help to us in the sense that the systolic pressure obviously was not too high and that we are not dealing with a cardiac disease characterized by a wide pulse pressure. She had leg cramps, dizziness after standing for long periods, and had had a brief episode of syncope associated with rapid heart rate and diaphoresis. Her past history is that of "rheumatism," which may or may not be of value to us in our later considerations. It does open up the possibility, however, that we are dealing with someone who may have had one of the early manifestations of connective tissue disease since this was an isolated episode and did not recur. She also tolerated pregnancies without complications, and this is always an important functional test for a woman with organic heart disease. At least her heart disease was not producing symptoms of heart failure during her pregnancies.

Her physical examination gave enough information to tell us that she had severe organic heart disease. The blood pressure is not particularly meaningful, but it does take the emphasis off certain other phenomena such as the wide pulse pressure of aortic regurgitation or the problems of severe systolic hypertension. Her distended jugular venous system is not further defined in terms of what types of waves were seen, but the distended jugular veins plus the murmurs that are described indicate tricuspid and pulmonic regurgitation, and since they were transient it would suggest to us that they were caused by elevation of the right heart pressure probably related to her failure. This subsequently improved since the murmurs disappeared.

She also had a left parasternal heave, and her first heart sound was accentuated without an opening snap. This is an extremely important point since it would mean that the mitral valve was probably flexible and mobile and that the motion of the valve was not disturbed. There was no opening snap, the second sound was slightly accentuated, and there was a gallop rhythm of the third heart sound. The murmurs I have already commented upon. They are unusual types of murmurs and I can only interpret them as evidence of tricuspid regurgitation and/or pulmonary regurgitation which apparently disappeared after her failure was treated. The possibility that the systolic murmur of her first heart sound represented mitral regurgitation is a real one, but I

cannot find further substantiation for that here. There was a question of a pericardial friction rub, and she had rales and dullness at the right base.

The laboratory tests show proteinuria, an abnormally elevated latex fixation test, hypergammaglobulinemia with abnormal proteins, elevated 7S globulins, a nondiagnostic bone marrow, no LE cells, and normal skin and muscle biopsy. Of importance to us is the fact that her calcium and phosphorus were normal. The electrocardiogram showed a complete left bundle branch block and she subsequently developed atrial fibrillation. The x-rays we will return to in a moment because they have a great deal of the information that we want to discuss in some detail.

The clinical course is somewhat confusing since initially she showed a very rapid response to therapy, dropped 25 lbs. in weight (presumably due to loss of fluid), and her murmurs disappeared. There was also improvement in her x-rays and clinical condition. Then, relatively abruptly, she developed atrial fibrillation, abdominal pain, diaphoresis, fever, lower extremity pain, lethargy, leukocytosis, hypotension and cardiac arrest. The crowded events in the last few days of this woman's life are going to be very difficult to unravel since many of them may be related to congestive heart failure and may not represent a significant systemic disease.

I think there are two or three problems that we should address ourselves to: one is the type of heart disease we are dealing with in this patient; the second is the role of the intracardiac calcifications; and the third is the significance of some of her serologic abnormalities. Perhaps the first thing to discuss would be the x-rays, and I will ask Dr. Dunbar to give us his thoughts on them.

DR. DUNBAR: Her initial cardiac film showed cardiac enlargement with some double contour on her left side suggesting left atrial enlargement. She also had biventricular prominence. The calcifications suggest a calcified mitral annulus and calcifications in the interventricular septum. This is apparently dystrophic calcification, and I have seen this only in rheumatic valvulitis. I certainly think that she had mechanical difficulties with the mitral valve, and I think that she had acquired valvular heart disease with abnormal mitral function.

DR. WOOLEY: Dr. Dunbar has made most of the pertinent points about the calcifications from the diagnostic and radiographic point of view. I think radiologists, cardiologists, and probably pathologists are amazed how frequently structures within the heart are calcified. As the radiographic methods improve, the incidence of calcification discovered by radiographic examination increases tremendously, and we now commonly recognize coronary artery calcifications and calcifications within the myocardium and the valve structures as well.

The first point I would address myself to is, What type of heart disease did this young woman have? Obviously, it is not a very straightforward situation. We have no good evidence of the usual types of heart disease. I will not go through these in detail to exclude them. I will just say that for the most part I would not accept the diagnosis of the usual types of heart disease in this case. The clinical behavior is essentially that of a cardiomyopathy which has been called primary myocardial disease or PMD. Her clinical behavior, her antecedent history, her cardiomegaly, and the response of her failure to therapy would all suggest some primary myocardial process. There have been multiple classifications of this condition but it is not my purpose to go into this discussion today. The classification suggested by Goodwin is somewhat more pertinent to us in day-to-day practice and speaks of restrictive and obstructive types of myocardiopathies. This woman's heart disease with cardiomegaly, transient murmurs, and death in a relatively short period of time, belongs to the restrictive type. In this group there is very little information about the presence of myocardial calcifications.

Her complete left bundle branch block would suggest extensive myocardial damage. It usually means that there is some sort of diffuse myocardial process within the left ventricle itself. Left bundle branch block in the presence of established heart disease is an ominous sign in itself, and follow-up studies of patients with complete left bundle branch block and symptomatic heart disease reveal rather short longevity curves for these people. Her past history of arthritis and her serologic abnormalities would also suggest the possibility of a systemic vasculitis or connective tissue disease.

What role did the presence of calcifications play in the patient? It has been known from the pathologic point of view much more than from the clinical point of view that calcification of the coronary artery is quite a frequent event. Frequently patients with patent ductus in the older age group will manifest calcifications. Often this is associated with pulmonary hypertension and there are situations in which one can make a radiographic diagnosis of a patent ductus merely by seeing the appropriate rim of calcification in the ductus itself. Calcification of the pulmonary artery occurs only when the pressure in the pulmonary circuit is elevated, and pulmonary artery calcification usually means pulmonary hypertension.

Valvular calcifications are quite common, and any of the congenital or rheumatic heart disease are the most common, but these are different types from the problem that we see here today with calcifications within the valve substance itself. Myocardial calcification in itself may occur under a variety of circumstances. These have been classified as metastatic calcification, where there is hypercalcemia present

and calcium salts are deposited in tissues that were previously normal and dystrophic calcification where usually this calcium deposit occurs in necrotic or fibrotic tissues. Massive calcifications may occur at times in an infarcted area or in the wall of a ventricular aneurysm, but here again we are talking about coronary artery disease and myocardial infarct.

In 1962 a group of Harvard investigators described an entity that they referred to as calcification of the mitral annulus. This is a massive calcification of the mitral annulus which may or may not alter the mitral valve function. They defined this as a clinical entity which occurred predominantly in elderly women whose average age was 75, most of whom had congestive heart failure. All had mitral systolic murmurs, atrial fibrillation was frequent, and the leaflets and chordae tendineae showed no microscopic evidence of rheumatic heart disease. They considered this a noninflammatory disease; however, they thought it produced in most cases hemodynamic abnormalities of the mitral valve. The important fact is not only the amount of the calcification but the manner of its extension into the leaflets, thus immobilizing the leaflets. This calcification developed around the annulus, immobilizing the mitral ring, and the usual sphincter-like action of the mitral annulus was lost with this type of calcification. These investigators considered these changes to be the result of a degenerative process.

So it would appear that calcification can occur in a large number and variety of situations, that there is no clear-cut differential diagnosis, particularly when we include massive myocardial necrosis with calcification or calcification of the mitral annulus. There are no clear-cut definitions from the etiologic point of view in these particular areas here. Our case has certain similarities with the entity that Korn, Desantis and associates¹ described; however, it does not fit completely, particularly since the calcification in our case extended down into the septum and into the ventricular myocardium.

There is one other topic that I would like to comment upon: that is, the serologic abnormalities that we found in our patient. High levels of the latex fixation test usually signify one of the complications of rheumatoid arthritis—that is vasculitis, Felty's syndrome, and various other types of collagen problems. However, there is no way that I know of to make a diagnosis of rheumatoid heart disease without having established rheumatoid arthritis.

Is it possible to have rheumatoid heart disease without having recognizable or established rheumatoid arthritis? I will leave that one for our pathologist to answer. Rheumatoid heart disease is a disease with pathologic manifestations of the protein metabolism. These lesions may include rheumatoid granulomata, diffuse myocarditis, and nonspecific endocarditis. Interestingly enough, there is a significant incidence of sclerotic changes under the bases of the valves,

in the valve rings in these patients, and these areas are the sites of predilection for the rheumatoid granulomata. So from a speculative point of view we might suggest that her high latex fixation titer might indeed be indicative of a rheumatoid process with vasculitis and raises the very interesting speculation as to whether the episode of her rheumatism as a youngster was the only clinical episode of rheumatoid arthritis. There was no evidence of deforming joint disease.

If we consider all this together, what final clinical diagnosis can we make? One fact that we obviously established is that she had severe organic heart disease. Her predominant problem is that of endomyocardial fibrosis with extensive calcification of the mitral annulus with minimal valve involvement and extension of the calcification into the septum and probably into the papillary muscle. Clinically she behaved as a case of myocardopathy with cardiomegaly, congestive failure, atrial fibrillation, and I would suspect pulmonary emboli. Lastly, I think that the etiology was not rheumatic fever. This was not a classic rheumatic heart disease and I do not know exactly what the etiology was. However, I would suggest the possibility of rheumatoid heart disease without deforming joint disease, with an associated vasculitis affecting the coronary and systemic vessels. The cause of death I would place under the category which Dr. Cuppage will find difficult to define. I do not think we are going to find a definitive or specific cause of death, although I will await the autopsy findings with great interest. I think at that point, I will close my discussion.

CLINICAL DISCUSSION

DR. GREENBERGER: The patient seemed to be doing all right until the 17th hospital day, at which time she had a biopsy of the right calf and then on the afternoon of the biopsy she developed severe cramping abdominal pain and a temperature of 101 F. *Have you any specific thoughts as to what might have happened?*

DR. WOOLEY: I don't have a good one. We have seen patients with heart failure have pulmonary emboli as a result of minor manipulative procedures and it might be that this type of complication occurred here. I don't think she had a gram-negative sepsis.

MEDICAL STUDENT: *Would Dr. Wooley discuss the etiology of the honking murmur and say something about the possibility of sarcoid in this patient?*

DR. WOOLEY: There are two types of cardiac involvement in sarcoidosis: one is involvement of the myocardium by sarcoid itself with frequent occurrence of heart block; the second is extensive pulmonary involvement with secondary cor pulmonale. As for the honking murmur, we think that honks are intracardiac phenomena and frequently are related to

peculiar types of atrioventricular valve regurgitation. In our patient here, I would think it arose from the tricuspid valve, since it went away with improvement of the right heart failure, but the possibility does exist that it was related to the calcification of the mitral valve.

MEDICAL STUDENT: I was wondering what the explanation was for the elevated 7S globulins.

DR. PENN: This is a nonspecific humoral response to inflammation.

CLINICAL DIAGNOSIS

1. Primary myocardial disease, possibly rheumatoid heart disease, with: (a) calcification of the annulus of the mitral valve; (b) calcification of the myocardium.
2. Congestive heart failure.

PATHOLOGIC DIAGNOSIS

1. Acute and chronic myocarditis: (a) subendocardial and myocardial calcifications; (b) focal necrosis of the myocardium.
2. Pulmonary arteriosclerosis.
3. Recent infarcts of the kidneys.

DISCUSSION OF PATHOLOGY

DR. CUPPAGE: I would like to discuss the changes we found in the heart. The rest of the changes are really not significant and are of little interest.

Her heart weighed 540 Gm. The right chambers were somewhat dilated in comparison to the left chambers. The myocardium of the left ventricle was 1.5 cm. thick, that of the right ventricle 0.5 cm. The mural endocardium, especially that in the left ventricle, was markedly thickened, whitish and firm. Its thickness was estimated at 2 mm. The valves were thin and without deformities or vegetations. The tricuspid valve measured 14 cm. in circumference, the pulmonic 6.5 cm., the mitral 9 cm., and the aortic 6 cm. The myocardium was very firm.

Areas of subendocardial calcifications were noted in the left ventricle affecting one portion of the upper septum. Most of the calcifications were located in the upper segment of the left ventricle either in the anterior or lateral posterior wall. The papillary muscles of the left ventricle were also markedly hypertrophic and contained areas of calcification. A calcified ring in the subendocardial myocardium surrounded the aortic infundibulum and the mitral valve. The inferior half of the left ventricle was free of calcification. Fibrosis was present in both endocardium and myocardium. No acute myocardial infarction was noted. The left artium contained small elevated plaques of fibrosis especially beneath the left auricle and around the pulmonary veins. The papillary muscles of the right ventricle were slightly hypertrophic. The right chambers contained a few small postmortem blood clots. The coronary arteries

were patent and thin. The root of the aorta was smooth and glistening.

The microscopic examination of the heart showed large deposits of calcium in the subendocardial tissue. No bacterial colonies or fibrinous exudate were present. In addition we found areas of chronic and acute myocarditis throughout the entire myocardium of both atria and ventricles. These areas consisted of multifocal and confluent foci of inflammation showing all variants from a chronic inflammation with large numbers of fibroblasts to areas of acute inflammation with large numbers of polymorphonuclear leukocytes. In each of these areas focal myocytolysis could be observed with necrosis of individual muscle fibers. This necrosis of myocardial fibers seemed directly related to the severity of the inflammatory reaction and was not of the primary anoxic or ischemic type. Numerous small mural thrombi were found on the endocardial surface covering the areas of myocarditis and calcification.

I don't know why this patient died but I would would guess that it was more likely a death due to some type of arrhythmia related to the widespread myocarditis. As to the etiology of her myocarditis we must admit that we are unable to give a definite answer. We can rule out rheumatic fever. As for rheumatoid heart disease, I would agree with the discussants who have stated that the diagnosis of rheumatoid heart disease should be made only in the presence of rheumatoid arthritis. I think this is perhaps a viral, perhaps a bacterial, primary myocarditis with superimposed chronic long-standing calcifications.

General Discussion

DR. TENNENBAUM: *Could this conceivably be a similar type of process akin to polymyositis with calcinosis involving the heart rather than skeletal muscle?*

DR. MONTELEONE: The changes in the heart are secondary to the inflammatory process. In polymyositis we usually have muscular degeneration preceding the inflammation.

DR. TZAGOURNIS: *Do you have any idea how long it takes for calcifications to occur after some metabolic, infectious, or physical injury of the heart muscle?*

DR. WOOLEY: I found one case report where the myocardium in an eight-year-old boy calcified within six days after an open-heart operation.

DR. BABA: I think myocardial calcifications are not unusual, and small lesions can occur without any functional changes. We see it often in cases of uremia and it has been experimentally produced in animals after viral infection of the heart.

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NEWS AND *Organization Section*

AMA Clinical Convention...

Houston, Texas. Will Be Scene of Scientific Program.
November 26-29; Numerous Feature Highlights Announced

A SCIENTIFIC PROGRAM especially designed for the physician in practice again will be featured at the American Medical Association's Clinical Convention, to be held in Houston, Texas, November 26-29.

The four-day meeting will include scientific sessions on 18 major topics, four postgraduate courses, breakfast roundtable conferences, closed-circuit television and medical motion picture programs, and more than 150 scientific exhibits.

Of special interest are the postgraduate courses, expanded to four topics: Fluid and Electrolyte Balance, Oncology, Cardiovascular Disease, and Obstetrics and Gynecology. Each course will consist of three half-day sessions featuring outstanding teachers.

Scientific and industrial exhibits and all scientific meetings will be in Houston's new Astro Hall, a part of the Astrodome complex.

Topics at the general scientific sessions include: aerospace medicine, antibiotics, arthritis, cancer, cardiovascular medicine, cardiovascular surgery, dermatology, endocrinology, gastroenterology, general surgery, genitourinary treatment, geriatrics, obstetrics and gynecology, ophthalmology, otolaryngology, pediatrics, and psychiatry. There also will be a session on "new cares" featuring a discussion of legal and social problems now faced by the physician.

Discussions for Breakfast Roundtable Conferences will include (1) Indications and Limitation of Uses of Antibiotics, (2) "The Moral and Ethical Aspects of Caring for the Dying Patient," (3) "Management of Cerebrovascular Insufficiency," and (4) Adolescence, Age of Rebellion; Some Related Psychiatric

Aspects." Numbers 1 and 2 will be Tuesday morning, November 28; numbers 3 and 4 will be Wednesday morning, November 29. Tickets will be \$3 each.

An outstanding program of closed-circuit color television and more than 25 medical motion pictures will be presented. Live, color television broadcasts of surgery and discussions from Houston's Hermann Hospital will be seen on a large screen in Astro Hall. Medical motion pictures will include three or four premier showings, plus several films that were well received at the AMA annual convention last June.

The AMA House of Delegates will meet at the Shamrock-Hilton Hotel.

* * *

Medical Aspects of Sports Meet Featured at AMA Conference

The team physician and the practitioner who has athletes among his patients should find many topics of interest at the 9th National Conference on the Medical Aspects of Sports in Houston, Sunday, November 26.

Clinical problems in athletics, sports cardiology, knee injuries, the 1968 Olympics at Mexico City, and specialized sports will be topics of forums and discussions.

Morning, afternoon, and evening sessions will be at the Hotel America. Sponsored by the American Medical Association's Committee on the Medical Aspects of Sports, the annual conference is held in conjunction with the AMA's 21st annual Clinical Convention, November 26-29 in Houston.

Speakers will include physicians experienced in sports medicine and other widely recognized sports

authorities. Those attending will have opportunities after each session to discuss special problems with the speakers.

Featured speaker at the conference luncheon will be Eduardo Hay, M.D., of Mexico City, director general of the Centro Deportivo Olimpico Mexicano, who will discuss preparations for the 1968 Olympic Games.

A session later in the day will discuss the U.S. Olympic athlete. Speakers will include the U.S. Olympic team physician, Daniel F. Hanley, M.D., of Brunswick, Maine; the U.S. Olympic vice president Merritt H. Stiles, M.D., of Spokane, Wash., and the executive secretary of the National Athletic Trainers Association, William E. Newell, R.P.T., Lafayette, Ind.

Some program highlights:

The problem of gastroenteritis is both significant and perplexing to athletes who need to be in top shape daily, at home and on the road. Clayton L. Thomas, M.D., of Wilbraham, Mass., member of the U.S. Olympic Committee's Medical and Trainers Services Committee, will discuss measures that can be taken to minimize this threat.

The relationship of cardiac problems to athletic participation will be discussed by Kenneth D. Rose, M.D., director of research at the University of Nebraska Health Service, Lincoln. Dr. Rose has done

research in medical telemetry, and will discuss how the heart actually responds during exercise, as disclosed by telemetric readings.

* * *

AMA Sponsors Utilization Review Program at Houston Meeting

"Utilization Review—Problems and Promise," will be the theme for the Second National AMA Conference on Utilization Review to be held at the Shamrock Hilton Hotel, Houston, Texas, on Saturday, November 25. The conference is on the eve of the AMA Clinical Convention.

Phases of the topic to be discussed include, Patterns of Use; Utilization Review and Third Parties; Establishing Standards; Regional Coordination; etc.

The conference is sponsored by the AMA Council on Medical Service, Committee on Medical Facilities. Reservations may be made with, or details obtained from, American Medical Association, Department of Hospitals and Medical Facilities, 535 N. Dearborn Street, Chicago, Illinois 60610.

* * *

Forms and instructions for preregistration and for hotel or motel accommodations are appearing in current AMA publications. Physicians are advised to make reservations early and to make reservations on printed forms.

The Month in Washington...

Here Are Some Reflections of the AMA's Voice in the Nation's Capital; AMA President Speaks on Medicare

EDITOR'S NOTE: The following information is from the regular monthly summary of the Washington news prepared by the Washington Office of the AMA and forwarded to the *OSMJ*. A monthly publication is at a disadvantage in reporting "current events" in Washington. The reader will make his own allowances for time lapse.

The Month in Washington

THE American Medical Association strongly opposed a suggestion that doctors' fees under medicare be based on Blue Shield schedules. The suggestion was made to AMA officials while they were testifying before the Senate Finance Committee on the House-approved social security bill which includes amendments to the medicare and medicaid programs. Dr. Samuel R. Sherman, San Francisco, chairman of the AMA's Council on Legislative Activities, said there would be heavy opposition

from the medical profession to any change from the present usual-and-customary fees.

Dr. Milford O. Rouse, president of the AMA, gave general approval to the bill passed by the House which, he pointed out, incorporated a number of changes recommended by the AMA. He said further substantive changes better could await the knowledge that one or two more years of experience would bring. However, he urged that consideration then be given to major changes in Medicare Plan B which covers physicians' services.

"We believe it is possible for the Congress, the medical profession and others interested in the subject to develop a new mechanism for delivering medical care to people over 65 that would be consistent with existing private sector mechanisms," Dr. Rouse said.

"Private" Health Insurance

"... the Congress realizes it has an open-end program with rising and perhaps uncontrollable costs.

We believe that it is possible, and would be eminently practical, to devise another approach that could solve problems which beset Part B. One possibility, for example, might be to substitute for the Part B program a subsidy to all eligible persons, to be used for the purchase of private health insurance. Such an approach could have many advantages.

"The eligible over-65 patient would have a qualified private insurance program of his choice, at no greater expense than he has under the Part B Medicare program; carriers would have a greater responsibility for their own performance with an opportunity to exercise initiative; the physician would continue to deal with his over-65 patient in every respect in the same way as he did before the patient's birthday; and the Congress would have a program with defined costs, and one which would offer the nation a comparison of mechanisms in use to meet the problems of financing health care of the elderly."

Other Points

Other points in the AMA testimony included:

Beginning with the provisions of Title XVIII (Medicare), the (House) bill does not place the disabled of all ages under Medicare, as had been proposed earlier. We think the House acted wisely in establishing instead, a special Advisory Council to study the problems related to the inclusion of this group and to study the costs involved.

In addition to the present method of payment for physician's services, the (House) bill provides two new options: either the physician can submit his itemized bill directly to the carrier, in which case payment of 80 per cent of the reasonable charge would be made to him, providing the full charges does not exceed the reasonable charge, or to the patient at his direction; or the patient may submit the itemized bill and be paid 80 per cent of the reasonable charge. From the program's inception, the AMA has urged that the payment be permitted on the basis of an itemized statement of charges.

Outpatient Services

Outpatient hospital diagnostic services would be transferred to Part B of Title XVIII and be subject to the deductible and co-insurance features. This is in keeping with our recommendation to the House Ways and Means Committee that outpatient services be included under Part B, and so remove the administrative difficulty of distinguishing between therapeutic and diagnostic services.

The bill eliminates both the requirement for initial physician certification for hospitalization of Medicare patients and the requirement for physician certification for outpatient hospital services. The AMA recommended the elimination of initial certification and the subsequent recertification. We continue to recommend the addition of this second step to eliminate

the requirement of any certification, since any need in this regard will be satisfied by the work of the medical review or utilization review committee.

We believe that physicians, having been brought under Social Security, should be accorded the same privilege and opportunity for reaching a fully insured status as was accorded other professional groups when they were included in the program. Accordingly, we urge this Committee to consider the adoption for physicians of an "alternative insured status" similar to that permitted by the amendments of 1954 and 1956 which brought into the program many new groups of people and professional self-employed persons, including lawyers. Further, we urge this Committee to consider amendments that would "drop out" an appropriate number of years for physicians to make their eligibility for cash benefits both equitable and realistic.

Drug Legislation

We must oppose the drug legislation offered before this Committee as amendments to H. R. 12080. We would suggest that rather than to enact such legislation it would be worthwhile at this time to study in depth, all the economic and therapeutic factors which enter into the use of prescription drugs.

The federal government has stepped up its campaign against cigarette smoking with the issuance of a new report and the appointment of a Lung Cancer Task Force.

A second Public Health Service report on the subject summarizes three and one-half years of research and study into the health dangers of smoking. The Department of Health, Education, and Welfare said the report confirms and strengthens the conclusions of a 1964 report. The second report provides new technical data on the relationship of smoking to cardiovascular, chronic bronchopulmonary disease, cancer and other conditions.

Polio Cases in United States Drop Off 99.9 Per Cent

Polio cases throughout the United States were down to 15 during the first seven months of 1967, virtually a 100 per cent drop in incidence since Salk vaccine was first used in 1955.

This represents the lowest national total on record, with only 10 states involved so far.

The Health Insurance Institute, citing United States Public Health Service reports, said 13 of the victims had contracted paralytic polio.

The peak year for the often-crippling disease was 1952, when 57,879 cases were reported. Since then, the Salk vaccine, and the Sabin vaccine, introduced in 1961, have all but eliminated the polio threat in this country. In 1955, 28,985 cases were reported.—Health Insurance Institute.

PHS Report Strengthens Previous Warnings About Smoking

A Public Health Service report summarizing three and one-half years of research into the health consequences of smoking has been issued by the Department of Health, Education, and Welfare. Its conclusions were that the 1964 findings of the Surgeon General's Advisory Committee on Smoking and Health have been confirmed, and in many ways strengthened.

Part I of the report, which sets forth current information on the health consequences of smoking, was submitted to the Congress in July by Secretary John W. Gardner as part of his report required by the Federal Cigarette Labeling and Advertising Act of 1965. Part II, which provides technical reports on the relationship of smoking to cardio-vascular, chronic bronchopulmonary disease, cancer, and other conditions, is published for the first time.

The 200-page report, PHS Publication No. 1696, is for sale by the Superintendent of Documents, U. S. Government Printing Office, Washington, D. C. 20402—Price 60 cents.

The following conclusions are drawn as indicated in the report:

Of men between the ages of 35 and 60, approximately one-third of all deaths are "excess" deaths in the sense they would not have occurred as early as they did if cigarette smokers had the same death rates as nonsmokers.

Cigarette smoking is now the most important cause of chronic bronchopulmonary diseases and greatly increases the risk of dying from these diseases.

Men who smoke cigarettes have a death rate from coronary heart disease 70 per cent higher than that of nonsmokers. This increases to 200 per cent and even higher in the presence of other known "risk

factors" such as high blood pressure and high serum cholesterol.

Seventy-seven million days of work are lost each year in the United States which would not have been lost if cigarette smokers had the same rates of illness as nonsmokers.

A relationship between cigarette smoking and death rates from peptic ulcer has been confirmed, and data now suggest that a similar relationship exists between cigarette smoking and morbidity from this cause.

Hearing and Speech Building Dedicated in Cleveland

Dedication ceremonies were held recently in behalf of the Cleveland Hearing and Speech Center, opening the Nathan L. Dauby and Marie Hays Heiner Buildings.

Completed at a cost of more than \$1 million, the new buildings have four floors and will house specialized centers for treatment, teaching and research of speech and hearing problems. Dr. Irwin Brown is executive director of the Center and assistant clinical professor of otolaryngology, audiology and speech pathology at the Case Western Reserve University School of Medicine.

The Cleveland Hearing and Speech Center was established in 1945 by the Cleveland Association for the Hard of Hearing under the name it now carries. Among the center's possessions are microfilmed records of some 70,000 patients extending back over a period of 22 years. Dr. Brown expressed the conviction that these records are priceless sources of speech and hearing research.

The new buildings are named for Nathan L. Dauby, former president of the May Company and head of the Beaumont Foundation; and Mrs. Marie Hays Heiner, chairman of the Center's Board of Trustees and founder of the Center.



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PHYSICIAN AND HOSPITAL EQUIPMENT

MDs in the News

Dr. Harold V. Ellingson, chairman of the Department of Preventive Medicine at Ohio State University, has been elected secretary of the American Board of Preventive Medicine.

* * *

Dr. William E. Brown, former health commissioner for Springfield and Clark County, is the new director of medical services for the Columbus Health Department.

* * *

Dr. John N. McCann, Youngstown, was named first chairman of the board of trustees of the Youngstown State University.

* * *

The new \$300,000 laboratory of Mercy Hospital, Mt. Vernon, is to be known as "The John C. Drake Clinical Laboratory," in honor of Dr. Drake, physician of long standing in the Mt. Vernon community.

* * *

Dr. Clarence F. Murbach, Archbold, was the subject of a feature article in the *Defiance Crescent-News*. He retired two years ago at the age of 80.

* * *

Dr. S. A. Schmid, president of the Cincinnati Board of Health, recently announced the appointment of Dr. James D. Wharton as Cincinnati health commissioner. Dr. Wharton has been director of the Division of Community Health Services, U. S. Public Health Services, Washington, D. C.

* * *

Dr. Murray S. Jaffe is the new president of the Cincinnati and Hamilton County Unit, American Cancer Society.

* * *

Former residents and faculty members of the University of Cincinnati Medical Center Department of Psychiatry held a symposium in honor of Dr. Maurice Levine, director of the Department. This is his 20th year in that position. The celebration included a banquet in Dr. Levine's honor in the Sheraton-Gibson Hotel Roof Garden.

* * *

Dr. Joseph B. Stocklen, controller of chronic illness and tuberculosis for Cuyahoga County, is president-elect of the American Thoracic Society.

Air Pollution: Its Ill Effects On Individual Well-Being

Air pollution should be the concern of every individual, and the primary concern of the physician. This is recognized by the American Medical Association by its action in stating that there should be "maximum reduction of all forms of air pollution."

The hazard to health of air pollution as it now exists is generally accepted, although the degree of damage may be questioned. Morbidity and mortality studies indicate that air pollution has an effect on many of the respiratory diseases. The increase in the past few years of chronic bronchitis and pulmonary emphysema in large part has been attributed to pollution of the air. Air pollution may also have a direct influence on the incidence of the common cold, bronchial asthma, and cancer of the lung.

The so-called smog occurring or existing in many cities and other areas has a deleterious effect not only on the physical well-being, but on the mental health of many individuals. Deaths from the effects of smog have occurred both in the United States and other countries. Reports of these occurrences have been published from time to time, giving the number of deaths, as well as those made seriously ill, due to such conditions. — By I. C. Riggins, M. D., Amherst — One of a series of briefs presented in behalf of the OSMA Committee on Environmental and Public Health.

OSMA Executive Secretary Named To Governor's Committee

Hart F. Page, Executive Secretary of the Ohio State Medical Association, and this year's President of the Ohio Trade Association Executives, has been appointed to the Governor's Committee to honor Ohio's Congressional Medal of Honor Winners at Valley Forge, Pennsylvania. The announcement was made by Fred J. Milligan, Columbus attorney, and chairman of the Committee.

Milligan, who is president of the Ohio Information Committee and was appointed by the Governor to head the project, said the Committee will raise funds to provide a monument, benches, paths and markers on "Ohio's Acre." The project is sponsored by the Freedoms Foundation to honor the Nation's top war heroes from every state. Of the 3000 who have received the award since 1863, more than 200 have been accredited to Ohio.

In announcing the appointment, Milligan said: "It is the Governor's desire, and the Committee's plan, that everyone in Ohio should be afforded the opportunity to participate in this worthy project.

ACCREDITATION NOTES . . .

A Question-and-Answer Column Conducted in Collaboration with
The Joint Commission on Accreditation of Hospitals
John D. Porterfield III, M. D., Director



Q. In a community with two nonteaching hospitals, with exactly the same staff in each hospital, would the Joint Commission consider joint sectional staff meetings, in order to help alleviate some of the demand put on physician's time?

A. While the Joint Commission is interested in conservation of physician time, the purpose of hospital staff or departmental or sectional meetings is to review the clinical work of that particular unit. While the staff membership may be the same, the clinical case content is not and can hardly be pooled or exchanged.

Several local medical societies have developed schemes for coordinating individual hospital staff meetings with the medical society meeting. This extends the time of the end to end meetings, but reduces the number of occasions. For example, if the hospital staff members were to meet an hour or two early before the regular monthly medical society meeting, they could review the work done in one hospital one time and the other the next. The place is not so important as that the attention be exclusively on the given hospital's clinical work.

Q. If over age 65 patients constitute a large part of total deaths, with the attending difficulty in getting permission for autopsy, will the requirement of 20-25 per cent autopsy rate still prevail?

A. As the standards are presently written, the answer is yes: 20 per cent in nonteaching, 25 per cent in teaching hospitals. However, the main intent is to enhance continuing education of the medical staff. Autopsies in all or most of the deaths representing interesting cases, unsolved diagnostic problems and the like are more important than 20 per cent of all hospital deaths, if the 20 per cent consists of routine and similar cases. Also, the doing of an autopsy is only the vehicle. More

significant is the actual discussion between the clinician and the pathologist about the clinical diagnoses and pathological findings involved. This standard is presently under serious review to see whether the objective can be better achieved by revision. Suggestions?

Q. With the availability of automated typewriters, will it be permissible for staff physicians — surgeons and radiologists, for example, to dictate a normal or standardized report in the case of a normal or routine procedure?

A. Yes, some hospitals now provide some form of automatic typewriter or even computer, and the Joint Commission does not object to their use as a form of dictation shorthand. It is essential only that the report be verified as correct and applicable by the author — the surgeon or radiologist, by his signature. There is concern, however, that this short cut not take the place of cortical activity by the physician involved. Check-off lists for history-taking and physical-examination recording often demonstrate this mouse-trap, where the hurried writer checks a box without conscious thought of what the record then says. It is disconcerting to see the entry on a chart: "Blood Pressure — Yes." Comforting, but not informative.

Q. Why has the Joint Commission not seen fit to explore or establish state-level representation?

A. If by this is meant representation on the Board of Commissioners, concerned interests are represented by seven commissioners named by the American Medical Association, seven by the American Hospital Association, three by the American College of Surgeons, three by the American College of Physicians (and now one by the American Association of Homes for the Aging and one by the American Nursing Home Association since extended care facilities are offered accreditation services). Quality of care does not vary from state to state and the volume of work in any one state usually does not warrant a related

Questions from *The Journal's* readers may be directed to the Joint Commission on Accreditation of Hospitals, John D. Porterfield III, M. D., Director, 645 N. Michigan Avenue, Chicago, Illinois 60611, or to *The Journal* for referral to Dr. Porterfield and his staff.

Presentation . . .

In February of this year, Dr. Porterfield addressed a group of Ohio physicians at the annual Ohio Conference of County Medical Society Officers and Committeemen, and replied to questions presented from the floor. In short, this column developed out of discussions at that meeting and a need expressed on both sides for better understanding between physicians and the accreditation program.

All of the questions on this page were presented for Dr. Porterfield's consideration by Ohio physicians. He and members of his staff have devoted much time to replies and comments. To the best of *The Journal* staff's knowledge, this is the first time that such a column has been conducted primarily for readers of a state medical journal.

Dr. Porterfield is well known to Ohio physicians, as a former OSMA member, former director of the Ohio Department of Health, and former director of the Ohio Department of Mental Hygiene and Correction. After leaving Ohio, and before accepting his present assignment, he was Deputy Surgeon of the U. S. Public Health Service, and later coordinator for Medical and Health Sciences, University of California.

state-level representative group. Have I missed the point?

Q. In what ways, or has the Joint Commission sought to promote liaison between hospital boards of trustees and County Medical Societies?

A. No, it has not though neither does JCAH discourage hospital board liaison with County Medical Societies. It insists on close liaison, full communication and mutual contribution in policy formulation between boards of trustees and hospital medical staffs. The former with full responsibility, part of which it must delegate to the latter.

Q. Does the Commission have a concern about the increasing responsibility and dependence being placed on the licensed practical nurse?

A. The Joint Commission recognizes the substantial contribution to nursing personnel resources made by the licensed practical nurse. It recognizes, however, that she must be utilized within the limits of her license and the nursing services must be under the supervision of registered professional nurses. JCAH standards still call for constant (24 hours, 7 days) coverage of the nursing program by RN's and some hospitals have lost accreditation through failure or inability to provide this.

New Law Liberalizes Benefits for Vietnam and Other Veterans

President Johnson on August 31 signed into law a bill providing for significant increases in benefits for Vietnam veterans and for older veterans as well.

Called the "Veterans' Pension and Readjustment Assistance Act of 1967," most provisions become effective October 1.

Under one major provision, veterans of the Vietnam era, which began August 5, 1964, will receive compensation for disabilities at full wartime rates and will qualify for nonservice-connected pensions on the same basis as older veterans. Their widows and children become eligible for nonservice-connected death benefits.

While this provision becomes effective October 1, an allowance of \$250 for burial and funeral expenses of deceased individuals who served in the Vietnam era became effective a month earlier.

World War II veterans benefits by the new law by having the final cut-off date on eligibility for the G.I. Loan program extend to July 25, 1970, from July 25, 1967.

Some other provisions of the law extended benefits to certain of America's veterans, from the Vietnam era to the Spanish-American War.

Americans Got Over \$10 Billion In 1966 Health Insurance

Americans received more dollars in benefits from private health insurers last year than ever before, the Health Insurance Council reported.

The HIC, in its 21st annual report on the extent of health insurance in the United States, said that nearly \$10.2 billion was paid in benefits during the year, with \$9.7 billion going to persons under 65 years of age.

The HIC survey showed that at the beginning of 1967 over 158 million persons were insured for hospital expenses, almost five million more than the number covered a year earlier.

Of this total, 149 million were below age 65, said the Council.

The HIC report used data from insurance companies, government agencies, and Blue Cross, Blue Shield, and medical society plans.

Of the benefit grand total, insurance companies paid out nearly \$5.6 billion, including \$1.1 billion in disability income benefits; Blue Cross, Blue Shield, and medical society plans accounted for \$4.0 billion; and independent plans, about \$0.6 billion.

The benefit total, up 5.6 per cent from 1965, means that an average of nearly \$28 million in payments were made each day last year.



FIRST CALL FOR ENTRIES

SCIENTIFIC AND HEALTH EDUCATION EXHIBITS

1968 Annual Meeting, Ohio State Medical Association

May 13 - 17, Cincinnati, Ohio

OUTSTANDING among the features of the 1968 Annual Meeting of the Ohio State Medical Association, May 13-17, Cincinnati, Ohio (exhibit days May 14-17) will be the Scientific and Health Education Exhibits. This will be the first time OSMA will use the excellent facilities of the Cincinnati-Exposition Center. Let's make 1968 a record-breaking year on exhibits.

Presentations will be limited to (1) exhibits by Ohio physicians, Ohio medical schools, hospitals or similar organizations; (2) out-of-state physicians or out-of-state agencies on invitation; (3) voluntary health organizations.

Each exhibitor will be provided with a booth or wall space, a standard sign, necessary electrical outlets, shelves, transparency cases, and a reasonable amount of furniture. If additional special facilities, equipment, or furniture are needed for the proper showing of the exhibit, the exhibitor should consult the chairman of the committee, Samuel Saslaw, M.D., and obtain his approval. The Association will not pay for special facilities, equipment, and furniture unless the request is approved in advance by the chairman.

On the opposite page will be found an application blank. If you have material suitable for an exhibit, send in an application. If you know of a colleague or group of physicians who have interesting material to display, suggest that they do the same. Deadline for entries in the Scientific and Health Education Exhibits are January 30, 1968.

A watchman will be on duty during the meeting but it is agreed that exhibitors will indemnify and hold harmless the Ohio State Medical Association from all liability which may ensue from any cause whatsoever.

Cost of transporting exhibits to the meeting must be borne by the individual exhibitors as well as the costs of cards, signs, etc., which are a part of the exhibit.

The picture on the facing page shows the type of booth which will be provided.

The booths will be of uniform color and design. Back and side walls will be pegboard, making them extremely functional for accommodating all kinds of charts and specimens. Blue fluorescent fixtures are a part of the background and will be spaced on each exhibit to give adequate lighting. If special lighting is needed, this should be noted in application for space.

APPLICATION FOR SPACE

SCIENTIFIC AND HEALTH EDUCATION EXHIBITS 1968 ANNUAL MEETING. OHIO STATE MEDICAL ASSOCIATION Cincinnati-Exposition Center. Cincinnati, Ohio. May 13 - 17

1. Title of Exhibit: _____
2. Name(s) of Exhibitor(s): _____
- _____

Institution (if desired): _____

City _____

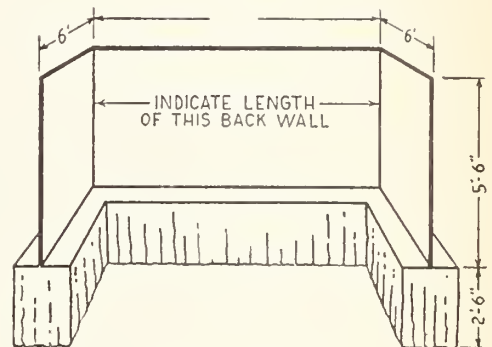
3. Do you have a built-in exhibit? _____
4. Description of Exhibit: (Attach 200 word description to this blank for use in Annual Meeting Program)
5. Exhibit will consist of the following: (Check which)

Charts and posters _____ Photographs _____ Drawings _____ X-rays _____

Specimens _____ Moulages _____ Other material _____

(Describe)

6. Booth Requirements:
- Amount of wall space needed? _____
- Back wall _____ Side walls _____
- Square feet needed? _____
- Shelf desired? (yes or no) _____



7. Transparency Cases:
- Needed? (yes or no) _____

If answer "yes," give following information:

Number of transparencies to be shown and size of each _____

Booths will have a back wall and two side walls. The side walls of all booths will be six feet wide. Back wall and side walls are eight feet high. If standard shelf is used, only 5½ ft. will be available for exhibit material. For most exhibits, a back wall, eight feet long will be sufficient. With the two 6 ft. long side walls, this gives a total of 110 square feet of wall space.

(It is suggested that transparencies should be no larger than 10 by 12 inches in order to conserve space. For size of view boxes which will be supplied by the Ohio State Medical Association if requested by you and how films should be mounted, see pages 3 and 4 of folder "Regulations and Information, Scientific and Health Education Exhibits, Ohio State Medical Association" which will be supplied to all applicants.

Date _____

Signature of Applicant _____

Mailing Address, Street _____

City, State, Zip Code _____

SEND APPLICATION TO: COMMITTEE ON SCIENTIFIC WORK, OHIO STATE MEDICAL ASSOCIATION,
17 SOUTH HIGH STREET, SUITE 500, COLUMBUS, OHIO 43215
DEADLINE FOR FILING APPLICATIONS, JANUARY 30, 1968

The Doctor Is Losing His Voice

Remarks of Paul Harvey, Chicago, News Analyst, Author, Columnist
23rd Annual Conference of Medical Society Presidents and Other Officers
Atlantic City, New Jersey, June 17, 1967

Good afternoon, Americans.

You know medicine.

I know something about socio-economics and much about public information.

Let's help each other.

Seven Years Wait for Surgery

In Britain, where "government medicine" has a head start on us, you may have to wait seven years for surgery!

In the United States, our Social Security taxes increased by a billion dollars this year. Even if there is no further expansion of this program, the cost in taxes will continue to increase over the next ten years.

Before the politicians of this Congress bait their hooks with any more "free medicine," we should study Britain's experience very carefully. It makes no sense knowingly to follow a blind leader into a ditch.

The British people are drifting back toward private health insurance. British United Provident Association privately insured the health of 73,000 Britons in 1950. But in 1960, they had covered 775,000. As of last year, this one Association was insuring the health of 1.2 million Britons.

Or take Prudential of London. Its private health insurance subscribers have multiplied fifteen times in fifteen years, doubled again in the past five years.

The reason that four million Britons now pay for National Health Service through higher taxes—but pay extra for private medicine—are the long waits for surgery and the hurried, impersonal examinations by NHS doctors.

The average United States doctor sees 169 patients in his office every week. In Britain, an NHS "government doctor" is expected to see 600 in a week!

The Wall Street Journal's Roger Ricklefs says a private patient in Britain may check into any hospital for any operation almost immediately. A state patient may wait six months or a year for nonemergency surgery. And for such things as hernia and varicose vein operations, he may wait seven years!

A typical patient who now pays extra for private treatment, Peter Dukes, Birmingham printer, 28, says, "I decided it's worth it to pay a bit."

And Peter Dukes' private doctor, Gilbert R. Smith, explains why he quit the welfare state medical system entirely:

"Under the National Health Service, it's practically impossible to practice medicine the way I like to work. I cannot give a proper examination in ten minutes, but when you have 35 patients in the waiting room, you are dominated by the thought of getting each examination over with in a hurry."

So from yet another example, we can see that socialism creeps backward as well as forward. Unfortunately, by the time the fallacies of "free medicine" are recognized, the people are already saddled with an overburden of taxes and it becomes almost impossible to dislodge the bureaucracy which feeds itself from that source.

"Government medicine" has proved to be potent vote bait in the United States—as it did in Britain. But it disguises a barbed hook.

The Man Who Isn't There

When there are no maids available, we can "make do." When gardeners are in short supply, Junior can handle the chore. When car washers are not available, we automate that task.

But when we cry out in the night for a doctor—and get no answer—we're in trouble.

Our Government is promising to spend much of our money on medical services, but money cannot buy services which don't exist!

It makes no difference how elaborate the politician's promises for Medicare, it cannot deliver what is not there.

President Johnson has projected elaborate, expanded plans for providing for the medical needs of everybody, from infancy through old age. He expects to get the money from us.

But where will he get the doctors?

In 1940 there were 350 doctors for every 100,000 American children.

Today there are only 150 doctors per 100,000 children!

Surgeon General, Dr. William Stewart, says, "Children today are receiving less medical care than they did 26 years ago. As a result, the infant death rate is increasing. Already fourteen other countries have lower baby death rates than the United States!"

So Bethesda is now instructing Navy wives in how to examine their own children; a "do-it-yourself clinic."

And while the number of Americans of all ages is increasing, the number of physicians is proportionately decreasing.

"Who wants to spend 12 years studying to become a bureaucrat?"

Trying to shift the burden to nurses doesn't work, because there's a chronic shortage of available nurses, too.

Dr. Jerome Schulman, Chief of the Department of Child Psychiatry at Children's Memorial Hospital, Chicago, says the mentally ill are the most woefully neglected.

"Of our nation's 1½ million hospital beds, half are occupied by mental patients. Each psychiatrist could right now have 750 patients in hospitals.

Available hospital space must be reserved for the most acutely ill; thus, for every patient now in a mental hospital, *ten should be*.

And the situation is worsening.

Unfortunately, many Americans construe campaign oratory for fact. Under Medicare, the fact is that the Government does not guarantee a hospital bed, it does not guarantee a doctor. It cannot. Government merely undertakes to pay most of the bill. There is no Federal obligation to supply services—just money.

And money cannot hire the man who isn't there.

Figuratively, Government has invited a hundred thousand people to a barbeque when there is food for only one thousand. Yet many members of Congress sought re-election last Fall by inviting more voters to partake of this meatless meal. Most will go home hungry, but the politician figures he can conjure up some jucier bait before the next election.

Until eventually, as in Britain, one after another of these "free services" is withdrawn, while the increased taxes go on and on and on. . . .

We Can Kill with Kindness

We can kill with kindness you know. Whenever I see Americans standing in line; whenever I see Americans demonstrating, demanding more Government handouts, I am re-reminded that we can, in fact, kill with kindness—that "good intentions" are not enough.

The Paul Harveys have lived recent years with a very painful, personal, daily reminder of this fact.

We over-fed our toy poodle on the sweets which the little fellow begged for.

It is important that you remember this: He did beg for them.

But he developed diabetes and became mostly blind. He failed to respond to oral therapy so every morning, seven days a week, for four and a half years, Angel took him to the veterinarian for his daily injection of insulin.

We had made him momentarily happy—but we had made him permanently dependent.

But we *know* so much better than we *do*—we Americans. So often we know what's right and we go right ahead and do what's wrong because we are not guided nearly so much by how much we know as by how we feel. We know so much better than we do. That's why a lot of pretty good Americans go around preaching free enterprise—and voting for Santa Claus. Because we know so much better than we do.

We know better than to smoke, but we are smoking three billion more cigarettes per year now than before the "scare."

I'm sorry. I apologize for presuming to expert a medical matter before this audience.

Actually I have been one not too secretly hoping that some of you would discover it's really television that causes cancer. Think about it. Then we could do away with both these evils—television and cancer—and all go back to smoking cigarettes again.

In the event this is being broadcast and before the opposition demands equal time to reply perhaps I should state that the cigarettes makers now advise me that they have fixed their products so that it does not cause cancer any more. Thank you.

The only thing is, have you noticed they have now had to make the filter so long you are likely to get a hernia from sucking so hard.

Ethics Unchanged

I have never given carte blanche endorsement to any individual or any organization.

The individual you endorse today might tomorrow be guilty of some durn-fool, indefensible utterance which discredits himself and friends. The organization, however well intentioned today, might eventually go astray—and there you are with your name on its letterhead.

You can go down the line with principles; those remain unchanged and unchanging.

The principles of medical ethics are today unaltered from the time when they were originally uttered by the Babylonians. The code by which you practice medicine today is unchanged from that of Charoka and Susruta—Hindu writers of unknown antiquity.

Your guidelines were re-enunciated by Christ and specifically defined by Hippocrates. They were restated in the Code of Percival in 1792 and eventually in the various pronouncements of the American Medical Association.

The practice of medicine has changed; the principles have not changed.

And however short we may fall of living up to the image, the ideals which you have inherited must remain uncompromised.

It is noteworthy that 120 years ago, when the AMA was founded, the two paramount items of business

dealt with minimal educational requirements and a code of ethics.

Now, if the doctor-patient relationship is to be supplanted by what Aldis called a "patient-committee relationship"—there is danger that historic obligations might become diffused. Allegiance to Government, however subtle, could cause the physicians sense of responsibility to the individual patient to become diluted.

Recently, we laymen have been confused and confounded by hearing men and women of distinction in your profession quoted on matters more political than medical . . . some of them urging that medicine be further socialized, espousing increased Government responsibility for our "welfare."

It is not as if your Federal Government ignores human need. Care for servicemen and their dependents, aid for the aged, all welfare grants are derived from "tax dollars." Thirty million Americans are now getting all or part of their medical care from government.

Yet renowned physicians lend their names to efforts further to provide "government medicine" for our citizens.

Why?

Is it because these doctors are themselves on the federal payroll? Is it because each of these derives part or all of his income from "government grants?"

Not one of the 26 "Physicians for Health Care for Aged through Social Security" is a full time practicing physician. They are a minute handful of the 200,000 members of the AMA.

Yet, because their names are news, they have influence all out of proportion to their numbers.

A man not in private practice is less likely to be "practical."

In Massachusetts General, Boston's ivory tower, most all research is "government sponsored."

Similarly Western Reserve has benefited from millions in "government grants."

The National Institutes of Health will dole out a billion of your dollars this year to support medical research.

Some medical school's research budgets are 87.6 per cent supported by government.

What I'm saying is that doctors who are on the government payroll, however indirectly, through grants from the National Institutes of Health, the Department of Health, Education, and Welfare, the Atomic Energy Commission, etc., have a third allegiance.

Understand, I do not impugn the integrity of these distinguished doctors. I refuse to believe they would sell their convictions for dollars, though the temptation is obvious.

But I am concerned that they allow their reputations in one field to lend undue importance to their advice in another.

Einstein was a mathematical genius and a political dunce.

Who Will Speak for the Doctor

So—a handful of articulate doctors are self-appointed spokesmen for the rest.

These are mostly men from government subsidized university faculties who are not engaged in the kind of private practice which they frequently choose to criticize.

From their ivory towers they contradict a primary ethic of their own profession—they presume to diagnose and prescribe from a distance.

I have never known a dedicated doctor who is opposed to humane care for the aged or the poor or who shirked his share.

Yet the image of the modern doctor is largely one of heartless, mercenary indifference because—and I say this with considerable respect for the splendid efforts of Dr. Ed Annis—the medical profession has had no grass-roots cheerleader since Morris Fishbein.

When medicine had no other spokesmen, he did not let its detractors get away with half-truths!

I don't like to have to wait in line at the doctor's office.

I resent the fact that my doctor does not work 168 hours a week.

I think I'm overworked when I work 11 hours a day, but it seems to me he should work 24.

Until I really think about it. But what's to make me think?

The professional man's contact with the rest of us has been inhibited by his ethics, by his preoccupation and by the fact that he studied medicine so long and works at it so hard there isn't time for much else.

And the doctor doesn't know much else.

He doesn't know about the symptomatic isms which infect the healthiest body politic.

He doesn't recognize the red metastases of the Marxist malignancy.

He doesn't comprehend that the big government which offers to keep us safe from ourselves has straightjackets in mind.

And for the doctor to ignore the basic laws of economics is as foolish as for a chemist to ignore the laws of valence—and altogether as potentially deadly.

When government takes our taxes to provide for our welfare, it's like a man trying to give himself a transfusion from his right arm to his left.

And when bureaucrats do it, they're likely to spill half of it in the process.

Historical Challenges

Your association is not unaccustomed to challenges and crises.

Apathy was your first adversary. When your AMA was born, two-thirds of all medical colleges ignored the birth.

(Continued on Page 1363)

The Doctor Is Losing His Voice

(Continued from Page 1354)

Subsequently, sectarian medical bodies resisted your efforts. Where today you must fight off those who would bureaucratize your profession, then you had to rise above the do-it-yourself healers, homeopaths, eclectics and cultists. Then, too, you were outnumbered and your own members divided. But the Association held together and worked together and survived—and thrived.

Medical Journalism was threatened with disrepute in 1898. There were 275 periodicals on health and disease, only a handful had any merit. But only a handful survived. *The Journal* survived.

In the 1880's the AMA was threatened with disintegration. But when a large group refused to accept the ethical standards of the organization, their membership was canceled. The Code survived. And the AMA survived.

Trying to get Government to prevent the adulteration of foods in the nineteenth century, you failed, but gained important experience in influencing legislative developments.

By 1900 you knew what NOT to do. And in 1906 you tipped the balance in favor of a pure food and drug act.

And in the Twentieth Century, this Organization accepted an influential role in public affairs, with drastic structural reforms in your Organization, you were responsible for humanitarian, educational, and disciplinary reforms a long time before anybody in Washington recognized either as an advantage or a need.

Always uphill . . . against obstructionists—some in your own organization.

Starting in 1910, with your Council on Health and Public Instruction, began the golden years of the AMA's public relations. And from that effort, I believe, evolved the unquestioned supremacy of your Association in the medical profession.

Insofar as possible, I am omitting names of individuals however important they may have been to the emergence of the Association, because we are here concerned with principles, not personalities.

But when I speak of Journalism, I am talking about something I do know something about.

The AMA Journal—under George Simmons and later under Morris Fishbein—spread the power and influence of the AMA at home and abroad. In addition to being a catalyst for your profession *The Journal* was a medical authority of unimpeachable stature for the press and the public.

With it you could fight nostrums and quackery and compulsory health insurance and you fought each fight and won them all . . . so long as your voice was loud and clear.

And your voice, technically and editorially, was *The Journal*.

But for most of two decades the Doctor has been losing his voice.

Perhaps what has happened since 1949 was an inevitable result of a public grown prosperous and fat, yielding its prerogatives to Big Government.

The politician who promised to spend the most of our money on us . . . we voted for.

And there was nobody to talk back.

The doctor is losing his voice.

You doctors are notorious for neglecting yourselves, so it is not going to be easy to make you adequately anxious about a case of laryngitis.

A Congressional investigation of allegedly overpriced drugs in hospitals is going to reflect discredit on the medical profession per se.

The headlines say, "One dollar for two aspirins to captive customer."

To suggest that the AMA might have ventilated this situation before the stench accumulated is to quarterback yesterday's game.

But that there has been inadequate liaison between the profession and the public is obvious.

Someone representing medical interests must answer headlined indictments with equal boldness.

The Doctor Is Losing His Voice

In handling medical matters the press characteristically tends to underscore the sensational.

Sometimes we can't help it.

A false alarm may be unavoidable in the instance of a novice researcher prematurely excited about some imagined breakthrough. Also, we shall always have with us some physicians who are less reluctant than others to focus attention on themselves with dramatic utterances.

But the greater risk to the public and to the profession derives from a misleading public statement on matters of medical ethics, philosophy and principle.

A news analyst cannot possibly be an authority on every subject which he is required to discuss. Generally, therefore, we come to rely on the counsel of experts in each field.

In a matter involving some facet of space flight, there are acknowledged spokesmen for both government and industry.

In most other physical sciences, it is comparatively easy to seek and find and consult with an official or quasi-official spokesman.

Big Steel has a spokesman; so do the Steelworkers.

In sports we take our questions to the persons with the best batting average. We ask questions on military weapons and tactics of military specialists whom history has proved right more often than wrong.

But in the urgent policy matters relating to medicine, where can we go?

Recently and presently the news media have most often accepted as "the last word" the word of the Surgeon General of the United States.

I do not believe the Surgeon General, however capable he may be, is the proper person to speak for the medical profession. He is a bureaucrat, necessarily parroting the party line of any incumbent political administration.

Recently, in such sensitive areas as federal money for private medicine, expanded social security, trade-name versus generic drugs, participation versus non-participation in Medicare, direct billing versus assignment, certification of medical necessity for Medicare and Medicaid, drugs costs and hospital rates, area-wide planning for hospitals, utilization review committees, the news media have been brainwashed with the "Government" point of view—because modern medicine has no other effective voice.

I say what I am saying with much respect for Dr. Blasingame whom I have sought out for guidance or a statement on some of these issues. But his prerogatives in enunciating socio-economic policy are presently hopelessly restricted.

Since the old jam-packed press conferences where *The AMA Journal* editor would announce the AMA diagnosis, prognosis and prescription in matters of national interest and public policy—the image of the medical profession has become blurred or blackened.

In respectfully recommending that the AMA again figure out some way effectively to speak through some one with one voice, I am aware of the risk involved. The spokesman might turn out to be a believer in the Big Government philosophy.

But I am willing to take that risk, because he can't be any further left than a politically appointed Surgeon General.

Every night at six, an audience of forty million televisioners is available to some articulate, uninhibited, preferably wavy-haired medical statesman-spokesman. And every night you don't supply one, the Government does.

Now . . . even in a terminal illness prognosis we would be careful to maintain what Dr. Paul Rhoads calls, "Honesty tempered with optimistic uncertainty."

Indeed, I am unconvinced that ours is, in fact, a hopeless case.

Today's youngsters are exposed to trigonometry in junior high school. By the time they are voting age they will know that two and two are four.

When they know this, tomorrow's politicians should not be able to sell them the Ponzi promise which they sold you and me; the promise that we can all stand in a circle with our hands in each others pockets and somehow get rich thereby.

When they have studied biology, physiology . . . how are tomorrow's politicians going to sell them the foolish notion that all everythings are created equal, when in fact no two anythings are.

And when they have re-re-read history, will they not surely learn that great nation states never spend

themselves rich. Inevitably they spend themselves poor.

I respectfully suggest that tomorrow's politicians had better start getting ready for a generation of voters who are going to be smarter than we were.

But just smarter is not enough. Just taller, and handsomer and healthier and more capable is not enough if they have lost that "old fire in the belly" which characterized their grand-daddies.

We're telling our young people that being an American is worth dying for and, what is sometimes more difficult, worth working at. They want to know if it is worth it. I think they are entitled to an answer to that question.

As we say in the Missouri Ozarks, "let's shuck right down to the cob." Just how indelible would your patriotism and mine have been if during our formative teen years our government had told us we might have to go 6,000 miles away to fight communism but if we try to fight it 90 miles from Florida we'd be thrown into jail.

Just how red, white, and blue would you and I have been if we'd been reared in an hour when our Government penalized those who tried to prosper in order to subsidize laziness and lethargy and illegitimacy.

How enthusiastically would you salute Old Glory if you have been sent off to fight foreign wars under a mongrel flag—wars which we appear ashamed to lose and afraid to win.

I'm not excusing the young demonstrators but I am capable of comprehending their frustrations and I am willing to accept part of the responsibility for it.

Because we in the press too often look at their future through the wrong end of the telescope. We focus attention on the misfit and the off beat and the exceptional. We underscore ugliness.

But for the same reason the coach reviews the errors in last week's game; so that his team won't make the same mistake again.

So this afternoon I have focused attention on one debit midst a century of credits.

Please don't misunderstand this critique.

You have managed such medical progress in your lifetime that we and our children can expect additional useful pain-free years of life itself!

You gave us that!

We are forever in your debt. Now—help us who so respect you—to help you in every way we can.

The Royal Society of Medicine Foundation, Inc., 20 Broad Street, New York, N. Y. 10005, has been formed to establish closer relations between members of the medical profession in Great Britain and the United States.

WHAT TO WRITE FOR

"The Sick Person Needs" . . . A report of the third national conference of physicians and professional nurses held February 23-25, 1967, in Coronado, Calif. Order from the Committee on Nursing, American Medical Association, 535 N. Dearborn St., Chicago, Illinois 60610; \$1.50 per copy. Copies of reports of the first and second conferences, "Medical and Nursing Practice in a Changing World," and "Nurse-Physician Collaboration Toward Improved Patient Care," are also available at \$1.50 each.

Prevalence of Chronic Conditions and Impairments Among Residents of Nursing and Personal Care Homes—U. S. May-June, 1964—Narrative description and data from the national health survey. PHS Publication No. 1000, Series 12, No. 8; 30 cents from the Superintendent of Documents, U. S. Government Printing Office, Washington, D. C. 20402.

Directory of On-Going Research in Smoking and Health — A 228-page directory listing, with brief description, 336 projects in this and 30 foreign countries. Financial support comes from federal and state governments, voluntary health agencies, universities, the tobacco industry, American Medical Association, various business firms, etc. Financial support of each project is indicated. PHS Publication No. 1665; Superintendent of Documents, U. S. Government Printing Office, Washington, D. C. 20402; price \$1.25.

Acute Conditions, Incidence and Associated Disability, United States — July 1965 - June 1966. One in a series of statistical studies; PHS Publication No. 1000 — Series 10 — No. 38; for sale by Superintendent of Documents, U. S. Government Printing Office, Washington, D. C. 20402; price 45 cents.

"Hospital Housekeeping — Wet Pick-Up" is the title of a film demonstrating how to wet vacuum a floor, one of many films available from the PHS Audiovisual Facility, Atlanta, Georgia 30333.

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Indications: Osteoarthritis, rheumatoid arthritis, rheumatoid spondylitis, psoriatic arthritis, acute gout, painful shoulder (peritendinitis, capsulitis, bursitis and acute arthritis of that joint), acute superficial thrombophlebitis.

Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently. Large doses of Butazolidin alka are contraindicated in glaucoma.

Warning: If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with great caution in the first trimester of pregnancy.

Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools or other evidence of intestinal hemorrhage occur. Make regular blood counts. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The most common are nausea, edema and drug rash. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ul-

For 280-lb. tackles — or 108-lb. housewives — Butazolidin alka can hasten recovery from the agonizing pain of shoulder bursitis.

It's not for every patient. Check carefully the Contraindications, Warning and Precautions shown below.

And adverse reactions may occur. The most common are nausea, edema and rash. Rarely, agranulocytosis has been reported. All adverse reactions are listed below, too.

Play-for-pay or workaday patients — when they come up with shoulder bursitis and your clinical judgment indicates Butazolidin alka — go with it.

And watch the comeback.



cer and may reactivate a latent peptic ulcer. The patient should be instructed to take doses immediately before or after meals or with milk to minimize gastric upset. Mild drug rashes frequently subside with reduction of dosage. However, rash accompanied by fever or other systemic reactions usually requires withholding medication. Purpuric rash has also been reported. Agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome, or a generalized allergic reaction similar to serum sickness may occur and require permanent withdrawal of medication. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

6509-V(B)R2

Butazolidin[®] alka

Capsules

100 mg. phenylbutazone
100 mg. dried aluminum hydroxide gel
150 mg. magnesium trisilicate
1.25 mg. homatropine methylbromide

Dosage in painful shoulder: Initial: 3 to 6 capsules daily in 3 or 4 equal doses. Trial period: 1 week. Maintenance dosage should not exceed 4 capsules daily; response is often achieved with 1 or 2 capsules daily.

For complete details, please see full prescribing information.

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Congress on Psychological Medicine . . .

Toledo Program, October 15; Dayton Program, October 29:
"The Many Faces of Depression" Will Be General Theme

THE SECOND Ohio Congress on Psychological Medicine will be conducted this fall on the basis of two regional conferences, one in Toledo on Sunday, October 15, and the other in Dayton on Sunday, October 29. General theme for the Congress is "The Many Faces of Depression."

The Congress is sponsored by the Ohio State Medical Association Committee on Mental Health, with the cosponsorship of the Ohio Psychiatric Association, the Ohio Academy of General Practice,

Toledo State College of Medicine Department of Psychiatry, and the Ohio State University Department of Psychiatry.

The Congress has been approved for 4½ hours of postgraduate credit by the American Academy of General Practice.

In both cities, registration opens at 9:30 A. M. (coffee furnished), with the first program feature at 10:00 o'clock. Programs run to 4:00 P. M.

Program at Toledo

Sunday, October 15

Academy of Medicine of Toledo

Welcome — Victor M. Victoroff, M. D., Cleveland, President Ohio Psychiatric Association.

Film — "The Mask of Depression"; moderator, B. L. Huffman, Jr., M. D., Toledo, President-Elect, Ohio Academy of General Practice.

Recognition of Depression in Adults — Henry L. Hartman, M. D., Toledo.

Recognition of Childhood Depression — Oscar B. Markey, M. D., Cleveland.

Panel Discussion — (participants in morning and afternoon programs).

Management of Depression in Children and Adolescents — William M. Easson, M. D., Toledo.

Management of Depression in Adults — L. Douglas Lenkoski, M. D., Cleveland.

Panel Discussion — (participants in morning and afternoon programs).

Program at Dayton

Sunday, October 29

Imperial House North

Welcome — Robert E. Howard, M. D., President, Ohio State Medical Association.

Film — "The Mask of Depression"; moderator, Wendell A. Butcher, M. D., Columbus, Chairman, OSMA Committee on Mental Health.

Recognition of Adult Depression — George J. Learmonth, M. D., Columbus.

Sources of Future Adult Depression as They Appear in Childhood — W. Hugh Missildine, M. D., Columbus.

Panel Discussion (Participants in morning and afternoon programs).

Management of Depression in Children — R. Dean Coddington, M. D., Columbus.

Management of Depression in Adults — Stanley L. Block, M. D., Cincinnati.

Panel Discussion — (Participants in morning and afternoon programs).

SECOND OHIO CONGRESS ON PSYCHOLOGICAL MEDICINE

"The Many Faces of Depression"

Check One: \$10.00 Per Person (includes luncheon)

☐ October 15, at Toledo Academy of Medicine, 3101 Collingwood Blvd., Toledo

☐ October 29, Imperial House North, Dayton, Ohio on Interstate 75 just south of Interstate 70

Registrant's Name

Address

Make Checks payable to: Second Ohio Congress on Psychological Medicine.

Mail to: Ohio State Medical Association
17 South High Street, Suite 500
Columbus, Ohio 43215

Ohio Medical Executives Hold Conference in Chicago

Eighteen members of County Medical Society executive staffs in Ohio and four members of the executive staff of the Ohio State Medical Association met in Chicago on August 22 for a conference primarily designed to promote closer liaison in medical organization work on the county, state, and national levels.

Dr. Robert E. Howard, Cincinnati, President of OSMA, attended the conference, addressed the group, and took part in discussions. Meeting place was the Board Room in the headquarters building of the American Medical Association.

Dr. F. J. L. (Bing) Blasingame, Executive Vice-President (chief executive officer) of the AMA, addressed the group, using as his topic, "What's New for the Coming Year?"

Other AMA personnel who addressed the group were Dr. Roy E. Ritts, director of medical research for the AMA; Richard Nelson, director of program development in the Field Service Division of the AMA Education and Research Foundation; Bill Ramsey, assistant director of the AMA Field Service Division; and Dr. Howard W. Doan, secretary of the AMA Council on Medical Service.

David Powers, representing the American Medical Political Action Committee, discussed the purposes and actions of that organization. James Imboden, who is stationed in Columbus as field representative of AMPAC, discussed the organizations activities in Ohio and described the purposes of the Ohio Medical Political Action Committee (OMPAC).

Edward Willenborg, executive secretary of the Academy of Medicine of Cincinnati, presided at the conference as president of the Association of County Medical Executives in Ohio.

Hart F. Page, Executive Secretary of the Ohio State Medical Association, discussed activities of the Ohio General Assembly with emphasis on the part played in legislative activities by physicians and County Medical Societies.

Those attending the conference from the County Medical Society executive staffs were the following: Miss Marie Motyka, Portage County; Miss Jean Armour, and W. "Bill" Webb, Franklin County; A. Dana Whipple, Medina County; Robert F. Freeman, and Earl Shelton, Montgomery County; Mrs. Barbara Wolfert, Erie County; John H. Austin, Stark County; Robert A. Lang and Alex Lagusch, Cuyahoga County; Robert Elwell, Lucas County; Sidney H. Mountcastle, Summit County; Edward Willenborg, Hamilton County; Mrs. Kay Tichnor, Trumbull County; Mrs. Owen A. McLaren, Lake County; Mrs. C. K. Elliott, Greene County; Mrs. Marion Wilcoxson, Clark County; and Mrs. Gladys Davidson, Lorain County.

From the Executive Staff of OSMA were Hart F.

Page, Charles W. Edgar, Herbert Gillen, and Jerry Campbell. A visitor at the conference was Frederic (Fritz) Fagler, Pittsburg, Pa., executive secretary of the Allegheny County Medical Society.

David Weihaupt, Field Service representative for the AMA, handled arrangements for the meeting.

Sponsored by OSMA, part of expenses of county executive staff members were paid by the Association upon approval by The Council. The conference was held on the eve of American Association of Medical Society Executives, and the annual Communications Institute sponsored by the AMA, and most of those who attended the Ohio conference stayed for the other meetings.

Officers of the association of County Medical Executives in Ohio in addition to Mr. Willenborg, who is president, are Mr. Webb, vice-president and Mr. Freeman, secretary-treasurer.

Medical Library Assistance Act Helps Libraries in Ohio

The Medical Library Assistance Act of 1965 (Public Law 89-291) authorizes programs of financial support to assist in meeting the Nation's need for adequate medical library services and facilities. The Act established grant programs for construction, resources, training programs, traineeships, postdoctoral fellowships, research projects, special scientific projects, publications, and regional medical library programs.

Medical Library Resource Grants are awarded by the Surgeon General of the Public Health Service to public and private nonprofit institutions for the purpose of expanding and improving their basic medical library or related resources. The program is administered by the PHS's National Library of Medicine through its Extramural Programs.

A list of 173 grants awarded to institutions in 39 states and the District of Columbia were announced. The following grants for Ohio institutions were included.

Children's Hospital Research Foundation, Cincinnati, \$5,779.

Good Samaritan Hospital, Cincinnati, \$2,311.

Institutum Divi Thomae, Cincinnati, \$1,603.

University of Cincinnati College of Medicine, \$1,438.

University of Cincinnati, Biology-Pharmacy Library, \$1,500.

Cleveland Metropolitan General Hospital, \$6,756.

Cleveland State Hospital, \$2,592.

Ohio State University Health Center Library, Columbus, \$1,166.

Columbus State Hospital, \$2,102.

Maumee Valley Hospital, Toledo, \$3,386.

Toledo State and Receiving Hospital, \$2,930.

University of Toledo College of Pharmacy, \$1,997.

Outstanding Scientific Exhibits

At OSMA Annual Meeting

ONE OF THE FEATURES at the 1967 OSMA Annual Meeting in Columbus, May 15-19 was the Scientific Exhibit and its companion Health Education Exhibit. From the many Scientific Exhibits on display the judging committee selected certain ones as outstanding. This procedure was in keeping with a recommendation of the Committee on Scientific Work approved by The Council. The authorized award in each case consists of a certificate of recognition, a permanent type plaque, and, in the case of the gold, silver, and bronze awards in the two fields of teaching and original investigation, monetary gift. A summary of exhibits selected to receive awards was printed in the July issue of *The Journal*, with four additional exhibits designated for honorable mention. Following are brief descriptions of additional outstanding exhibits. Write-ups on other outstanding exhibits will be published in forthcoming issues of *The Journal*.

Honorable Mention Goes to Exhibit On Dissecting Aortic Aneurysm

Honorable Mention in the field of original investigation was given to the Exhibit entitled, "Dissecting Thoracic Aortic Aneurysms—Drug Therapy," at the 1967 OSMA Annual Meeting. Sponsors were Norman H. Baker, M.D., and H. Gene Ewy, M.D., Ohio Heart and Thoracic Surgery Center, Columbus.

Following is a brief description of the exhibit and the phases of investigation presented.

This exhibit was displayed to show the efficacy of drug management in the acute phase of dissecting thoracic aortic aneurysm. Wheat and associates, at the University of Florida Medical School, introduced this mode of therapy in 1965. They found that cardiac impulse and subsequently aortic dissection could be controlled by specific drugs.

The three drugs, Trimethaphan (Arfonad) Reserpine, and Guanethidine were outlined and the dosages described.

Six consecutive cases were summarized. All six patients survived the initial acute dissection to leave the hospital on drug management. One patient died of unrelated causes and another of unknown causes during the period of follow up.

An interesting, associated vascular problem arose while following these patients. Aortography disclosed two of the six patients had "sheared off" a renal artery with the dissection. The kidneys were functioning satisfactorily by way of extra-luminal perfusion through the dissected area. This condition, if un-

recognized, could complicate definitive surgical treatment if required at a later date.

The sponsors conclude that drug management would appear to be the treatment of choice, at the present time, for the acute phase of dissecting thoracic aortic aneurysms.

Exhibit on Pulmonary Embolus Wins Silver Award in Teaching Field

The exhibit entitled, "Massive Pulmonary Embolus—Diagnostic and Surgical Approach," was declared the Silver Award winner in the teaching field at the 1967 OSMA Annual Meeting. Sponsors were James W. Kilman, M.D.; John S. Vasko, M.D.; William Molnar, M.D.; and Xaxier J. Riccobono, M.D.; all of Ohio State University Hospitals, Columbus.

Following is a brief description of the exhibit and the information contained in it.

The diagnostic approach for the differential diagnosis of the massive pulmonary embolus utilizing the plain chest film, pulmonary angiography and radioactive lung scan was presented. The indications for these studies were given and normals provided.

The surgical approach to this problem utilizing emergency cardiopulmonary bypass, pulmonary embolectomy and simultaneous inferior vena cava ligation was outlined. The equipment for emergency bedside cardiopulmonary bypass was demonstrated. A continuous movie strip of an actual pulmonary embolectomy was shown. Specific cases were presented including post embolectomy studies and results of surgical therapy.



Dr. Lawrence C. Meredith, 1966-1967 OSMA President, is shown holding the Silver Award Plaque presented to Dr. James V. Kilman and his associates for outstanding exhibit on pulmonary embolus.



Dr. Meredith is shown here congratulating Dr. H. Gene Ewy, one of the sponsors of the exhibit on dissecting aneurysms which won honorable mention in the field of original investigation.

Ad Astra

Robert Clarke Allen, M.D., Cincinnati; Miami Medical College, Cincinnati, 1907; aged 81; died August 6; member of the Ohio State Medical Association and the American Medical Association. Dr. Allen devoted most of his professional career to practice in the Cincinnati area, principally in the Glendale-Sharonville section. He was a veteran of World War I and a member of the American Legion. Other affiliations included membership in Christ Church. Four sons survive.

Anthony Patrick Conti, M.D., Pompano Beach, Florida; Stritch School of Medicine of Loyola University, 1930; aged 63; died August 4. A native of Youngstown, Dr. Conti spent most of his practice years in New York City. In recent years he was living in retirement. Dr. Martin E. Conti, of Youngstown, is a brother. Other survivors are his widow, four daughters, four sisters, and another brother.

Joseph Mitchell Dunn, M.D., Dublin; Ohio State University College of Medicine, 1915; aged 77; died August 6; member of the Ohio State Medical Association and the American Medical Association; past president of the Academy of Medicine of Columbus and Franklin County. Dr. Dunn was a practitioner of long standing in the Dublin community near Columbus and was associated with several Columbus hospitals. During World War I he served overseas and attained the rank of major. Affiliations included memberships in the Catholic Church and the Knights of Columbus. Survivors

include his widow, a daughter, two sons, two sisters, and two brothers.

Maurice S. Goldberg, M.D., Dayton; Ohio State University College of Medicine, 1932; aged 60; died August 23; member of the Ohio State Medical Association. A practitioner for many years standing in Dayton, Dr. Goldberg was a veteran of World War II. He was a member of the Temple. Surviving are his widow, a daughter, three sons, three sisters, and two brothers. One son, Dr. Robert Alan Goldberg is in the Medical Department of the Navy.

John Domenic Marioni, M.D., University of Cincinnati College of Medicine, 1931; aged 67; died August 8; member of the Ohio State Medical Association and the American Medical Association. A resident of Cincinnati since 1922 and a practicing physician there for many years, Dr. Marioni resided in the Hyde Park area. He was former Italian consul for southern Ohio. Among survivors are his widow, four sons, three sisters, and a brother.

Wells Coriell McCann, M.D., Wheelersburg; University of Cincinnati College of Medicine, 1935; aged 60; died August 11; member of the Ohio State Medical Association and the American Medical Association. A native of Scioto County, Dr. McCann devoted all of his professional career to practice there, first at Minford and later at Wheelersburg. He served on the county board of health and among affiliations belonged to the Elks Lodge. Surviving

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are his widow, a son, a daughter, a brother, and a sister.

Walter Samuel Price, M.D., Indianapolis, Ind.; Jefferson Medical College of Philadelphia, 1939; aged 54; died August 11; former member of the Ohio State Medical Association, and later a member of the Indiana State Medical Association; member of the American Medical Association, American Society of Anesthesiologists, and the International Anesthesia Research Society. Dr. Price practiced in Phillipsburg, Montgomery County, before and after World War II, during which he was in the Medical Corps. He moved to Indianapolis about six years ago. His widow and three children survive.

Max Serog, M.D., Cincinnati; Medical Faculty of the Georg-August-University, Gottingen, Prussia, 1909; aged 84; died on or about August 18; member of the American Psychiatric Association. A native of Germany, Dr. Serog came to this country in 1938 and became a citizen in 1945. Living in retirement in recent years, he served as staff psychiatrist at the Dayton State Hospital for about seven years. His widow survives.

William Ridley Sparling, M.D., Columbus; Ohio State University College of Medicine, 1939; aged 55; died August 26 while vacationing with his family in Canada; member of the Ohio State Medical Association, the American Medical Association, and the American Society of Abdominal Surgeons; Fellow of the American College of Surgeons. Dr. Sparling practiced for many years in Columbus, specializing in surgery. He is survived by his widow, two sons, a daughter, his mother, and a brother.

Clement Edward Steyer, M.D., Cleveland; St. Louis University School of Medicine, 1924; aged 68; died August 17; member of the Ohio State Medical Association and the American Medical Association. A native of Cleveland and long a practitioner there, Dr. Steyer retired about a year ago. His specialty was internal medicine. Among survivors are his widow, a daughter, a brother, and two sisters.

Zolton T. Wirtschafter, M.D., Portland, Oregon; aged 67; died August 18. Dr. Wirtschafter formerly practiced in Cleveland. During World War II he served with the Army Air Corps at Wright-Patterson Air Force Base, and after the war became associated with the Veterans Administration. His widow, two sons, and a sister survive.

The American College of Physicians is sponsoring a Michigan Regional program at the University of Michigan, Ann Arbor, October 27-28.

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Activities of County Societies . . .

LORAIN

Members of Lorain County Medical Society and their wives held their Annual Recognition Dinner on September 12, at the Aquamarine Lodge in Avon Lake, to honor the Board of Supervisors of the Lorain County Medical Foundation and their wives, and nine area students who were awarded scholarships to assist them in studying for careers in medicine and nursing. A total of \$2,200 was distributed. The Foundation was established several years ago by the Medical Society with the balance of funds after expenses of the Polio Campaign had been met. It is governed by a Board of Supervisors comprised of well-known community leaders, and the Society is represented on the Board by three physicians and the Society president who serves in an ex-officio capacity.

R. S. VanDervort, M. D., president of the Medical Society, welcomed members and guests. L. C. Meredith, M. D., Past President of Ohio State Medical Association, spoke on behalf of President Robert E. Howard, M. D., who was unable to attend, and Councilor of the Eleventh District, William R. Schultz, M. D., also addressed the group.

The Board of Supervisors was introduced by Carl M. Adams of Lorain, chairman of the Foundation, and the awards were distributed to the students by Owen F. Beckmeyer of Avon Lake, who serves as chairman of the Screening Committee.

Jack Schreiber, M. D., of Canfield, was the featured speaker of the evening. An accomplished speaker and entertainer, Dr. Schreiber's topic "Here I Stand" was most appropriate to the occasion. A large attendance marked this first meeting of the Fall season; as an annual event over the past several years, the Recognition Dinner has developed into a very effective public relations project.

LUCAS

The September schedule of the Academy of Medicine of Toledo and Lucas County included a meeting on Wednesday, September 20. Program topic was "The Real Medical Problems in Disability," the speaker being Dr. A. H. Hirschfeld, assistant professor, Psychiatry Department, Wayne State University School of Medicine.

MAHONING

A Physician-Lawyer Code has been adopted by the council of the Mahoning County Medical Society and the Mahoning County Bar Association. It is printed in the August issue of the *Bulletin* of the society.

The 16th annual medical health tent was sponsored at the Canfield Fair by the Mahoning County Medical Society. The 60x100 foot tent contained some 23

exhibits, representing various medical and health organizations in the area. The Society also sponsored manning of the first aid station at the fair.

Sixth District Postgraduate Day Scheduled in Warren, Oct. 25

The Sixth Councilor District Postgraduate Day will be held this fall at the Packard Music Hall in Warren, with the Trumbull County Medical Society as host organization. All interested physicians are invited to attend. The date is Wednesday, October 25.

Dr. George A. Sudimack, of Warren, is program chairman, the third time he has arranged the program for the annual event. Contacts in regard to the program may be made with Dr. Sudimack or with the Trumbull County Medical Society, 280 North Park Avenue, Warren 44481.

Registration opens at 8:00 A. M., with a CPC at 8:30 and the main features of the program beginning at 9:00 o'clock. Coffee will be served for early arrivals. A nominal fee covers registration and luncheon. The program concludes at 5:00 P. M.

Western Reserve Participates in Medical Careers Program

Some 36 students from 26 colleges and universities in Ohio and Pennsylvania participated this summer in a program designed to help them decide on medical careers. The students were selected by their schools on the basis of outstanding academic backgrounds and suitability to the medical field.

The project was part of the Medical Careers Program of the Smith Kline & French Foundation, associated with a well-known Philadelphia-based prescription drug firm.

Western Reserve University School of Medicine, Cleveland, participated in the program. Also five Pennsylvania medical schools participated. They are Hahnemann Medical College, Jefferson Medical College, University of Pennsylvania School of Medicine, Temple University School of Medicine, and the Woman's Medical College of Pennsylvania.

Title V Project Trains Students In Inhalation Therapy

Cincinnati General Hospital and the Hamilton County Welfare Department have launched a program to train inhalation therapists, which is backed by a \$29,000 grant from the county's Title V project.

Enrolled in the one-year course are 12 students selected by the Welfare Department from its clients. Title V of the U.S. Economic Opportunity Act of 1964 provides funds for programs to upgrade skills and employability training of adult welfare clients.

Woman's Auxiliary Highlights...

By MRS. S. L. MELTZER, Chairman, Publicity Committee

2442 Dorman Drive, Portsmouth 45662

THIS is the "lean time" of the year where Auxiliary activities are concerned. This copy, of necessity, is written early in September—considerably before the local groups have swung back into action after summer vacation. The only newspaper clipping to come my way was from Hamilton County's publicity chairman, Mrs. Robert E. Krone. And that was a most unusual auxiliary publicity clipping! The *Cincinnati Enquirer's* Woman's Club Editor devoted an entire feature to "Entertaining Board Members" and in this case featured the kind of refreshments for "board meetings, often held in the president's home". . . . And then, wonderfully, the hostess and president who was highlighted was none other than Hamilton's Mrs. Joseph Ghory! The article was devoted to an interview and some mouth-watering recipes. Wish I were a member of the board of Hamilton county (or had some excuse to visit Mrs. Ghory)!

I have commented before on the ability of the Hamilton County women to get almost unprecedented publicity in the local newspapers. I can appreciate how many local publicity chairmen reading this will sigh with envy. This is no easy feat—this kind of newspaper coverage, particularly in a community as large as Cincinnati and its environs. There must be a very happy combination there—two unusually co-operative papers and a "ball of fire" publicity chairman! Congratulations. . . .

"The Direct Line"

For some time, I have wanted to share with the readers of this column the pertinent and interesting data that comes to the leaders of state and county

auxiliaries via "The Direct Line" from the Woman's Auxiliary to the American Medical Association.

Naturally, the rank and file do not have access to the "Direct Line" copy, although I am sure most local officers share its thoughts with the membership. However, since there is a number of new ideas in this most recent of issues and since there has hardly been time for your own president and president-elect to share them with you, I am going to devote the rest of this column to quotes from that valuable little publication. (And just think how up-to-date you will be at your next meeting!)

Our own Gerby Ritter, national president, placed the spotlight on "Home-Centered Health Care." She speaks of the development of a new committee which has emerged after the outstanding progress of last year's special committees on homemaker service, volunteer friendly visitor training and meals on wheels. Well, all of these are now combined under one committee with the descriptive title of "Home-Centered Health Care." As Mrs. Ritter points out . . . "the idea is not new. One such program has been in operation since 1796 when the Boston Dispensary began providing physician and other services to indigent patients at home. . . . AMA has defined the modern implementation as 'any organized and centrally administered effort to provide, under medical direction, one or more services which will complement and support a physician's care of his sick or disabled patient at home.'"

A packet of materials on this care was given each state president and president-elect at the June

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convention. In addition, a package program on "Homemaker Service" is being developed jointly by the AMA, the auxiliary, and the National Council for Homemaker Services. It is designed primarily to help present the facts about homemaker service in communities where none yet exists. Mrs. Ritter reminds the auxiliaries about other valuable package programs: Venereal Disease in Teenagers, Immunization, Developing Youth Health Habits, Mental Health, Health Careers, and Block Mother. Such package programs may be ordered from the National Auxiliary at 535 North Dearborn Street, Chicago, Illinois, 60610. Requests will be filled as promptly as possible, but Mrs. Ritter wants this understood: only one packet on a given subject to each auxiliary—please!

New Committee

Another one—this time on Community Health. The board of directors of the AMA Woman's Auxiliary has just recently created this new committee to promote educational and service activities relating to health in both rural and urban communities, realizing the different needs and problems involved in each. In doing this, auxiliaries must, of course, seek counsel from their medical societies.

Programs which community health chairmen are urged to support include: annual physical examinations; cooperation with National Community Health Week; cooperation with community groups working to solve health problems; assisting with detection and screening programs and immunization programs; working to expose quackery where it exists; furnishing "Emergency Medical Alert" identification tags; providing special health programs for schools and civic groups through the use of package programs on venereal disease, mental health, physical fitness; placing *To-day's Health* in schools and community libraries.

Many safety campaign programs throughout the United States in 1966-67 had as special ingredients originality, grit and snap, according to the "Direct Line." Robeson County, N.C., auxiliary was awarded the Health Mobilization Award at the convention in Atlantic City in recognition of its accomplishment in involving 20 times more members of their community in medical self-help training than were involved the year before. The GEMS program flourished—from California where 6,000 girls were trained to small rural communities where ten or 12 much-needed babysitters got instruction. The Block Mother Plan took various forms—from Georgia's series of six films on child molestations which enlightened more than 30,000 children, to some small auxiliaries working in rural areas with PTAs. Here are some suggestions for local safety projects:

Mouth-to-mouth resuscitation demonstrations; medical self-help classes; defensive driving classes; poison control projects; mock disaster drills; con-

ferences on youth safety; work toward good legislation for traffic and highway safety; home safety campaigns; fire prevention; tornado safety programs; "patch the pony"; prevention of falls in older persons; blood bank staffing; and encouragement of participation in National Driver's Tests.

Health Careers

The Health Careers Committee this year is emphasizing a "Three R's" program: Recall, Review, and Recruit thusly: **Recall** adults who have been trained in health careers but who have not been active in the recent past, and urge them to take the necessary refresher courses to enable them to begin practice again; **Review** the education requirements in each field, realistically evaluating the needs of today and the training and preparation necessary to meet them; **Recruit** people of all ages to the health professions and occupations. All methods must be used to make our recruitment efforts more effective. We must continue to use the tools that have been found useful as well as to seek new ideas and procedures that will improve our methods.

The program of the national auxiliary's committee on legislation is a continuous process. The objectives are unchanging: (1) to assist the medical profession in the promotion of national and state legislation that will allow the continuation of high quality medical care for all people; (2) to inform auxiliary members and the public of the positions taken on legislative matters by the medical profession; (3) to assist the AMA and state associations when requested.

New Films

A sprightly film, "Girls Are Better Than Ever" is ideal for showing to pre-teens and teenagers. It deals with proper diet, weight control, exercise and personal hygiene in a manner that young girls will "dig." The film is made available as a public service by the American Dairy Association in cooperation with the President's Council on Physical Fitness. It may be obtained by writing to: Modern Talking Picture Service, 1212 Avenue of the Americas, New York, N.Y. 10036.

Three films dealing with the mental and physical health of children, produced by the Smart Family Foundation, are highly recommended for auxiliary program use: "Who Cares About Jamie" (16 min.) is concerned with children's emotional well-being and suggests ways that adults—especially parents—can help prevent mental illness; "Journey in Health" (22 min.) deals with children's physical well-being, stressing the importance of preventive medicine and regular physical checkups; and "Children on the Move" (22 min.) which suggests positive ways adults can help ease the emotional shock which often

(Continued on Page 1391)

results when a youngster is uprooted and transferred to an unfamiliar environment. Pamphlets describing each film are available from the AMA Film Library, 535 North Dearborn Street, Chicago. (All 16 mm. sound and color or black and white.)

For films relating to adolescence and early adulthood, the American Psychiatric Association has a list of 20 recommended films; or you may write to the National Auxiliary office for a film list.

Your Publicity

This doesn't come from the "Direct Line!" This comes from ME—your Auxiliary Highlights reporter for *The Ohio State Medical Journal*. It would seem that each and every local auxiliary would be more than anxious to have its "doin's" reported here—where your doctor-husbands can see, via the printed word, the important things you are doing. I KNOW for a fact that there isn't one of you who doesn't have one or more vital projects under way. But what I DON'T KNOW are all the details and the local tie-ins and the important personal "tid-bits" and just exactly what your meetings emphasize—and so on and so on! Send me your newspaper clippings each month. If your newspaper coverage is on the weak side, send me a typewritten account of what you're doing. But —please—SEND ME SOMETHING ABOUT YOURSELVES! The State Board is interested; the doctors are interested; and other local groups are interested in knowing what is being done elsewhere.

If you have publicity problems and would like some help, write me (2442 Dorman Drive, Portsmouth, Ohio 45662). I may not come up with all the answers, but I may be able to come up with some! Try me out. . . .

AMA Sponsors Disaster Care Program in Miami Beach

The application of the concepts of daily emergency medical care to the disaster situation will be analyzed at the First Biennial Symposium on the Management of Trauma and Disaster Medical Problems, in Miami Beach, Friday and Saturday, November 10 and 11, 1967.

Sponsored by the American Medical Association's Committee on Disaster Medical Care of the Council on National Security, the two-day symposium will be held at the Carillon Hotel.

For additional information write: Committee on Disaster Medical Care, American Medical Association, 535 North Dearborn, Chicago, Illinois 60610.

Cleveland Clinic Foundation Announces PG Courses

The Cleveland Clinic Educational Foundation has announced a number of postgraduate courses to be offered during the 1967-1968 season. Details on the various courses may be obtained by writing to Walter J. Zeiter, M. D., Director of Education, The Cleveland Clinic Educational Foundation, 2020 East 93rd Street, Cleveland 44106.

Following are the courses scheduled for 1967:

Update 1967 — Selected Topics in Nursing — October 18.

Problems in Pelvic Surgery, November 8-9.

Pain: Neurological and Neurosurgical Aspects — November 15-16.

Postgraduate Course in Ophthalmology — December 6-7.



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BUTLER—Brady Randolph, President, 128 North Front Street, Hamilton 45011; Mr. Charles G. Greig, Executive Secretary, 110 North Third Street, Hamilton 45011. 3rd Wednesday monthly.

CLERMONT—Noco Capurro, President, 481 Craig Road, Cincinnati 45244; Albert W. Van Sickle, Secretary, Box 365, Batavia 45103. 3rd Wednesday monthly except July, August and December.

CLINTON—H. Richard Bath, President, 290 West Main Street, Wilmington 45177; Mary R. Boyd, Secretary, Box 629, Wilmington 45177. 4th Tuesday monthly.

HAMILTON—Stanley D. Simon, M.D., President, 320 Broadway, Cincinnati 45202. Mr. Edward F. Willenborg, Executive Secretary, 320 Broadway, Cincinnati 45202. 3rd Tuesday monthly.

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DARKE—E. Westbrook Browne, President, 330 West 4th Street, Greenville 45331; Giles Wolverton, Secretary, Darke County Department of Public Health, Court House, Greenville 45331. 3rd Tuesday monthly.

GREENE—Richard A. Falls, President, 1148 North Monroe Drive, Xenia 45385; Mrs. C. K. Elliott, Executive Secretary, 225 Pleasant Street, Xenia 45385. 2nd Thursday monthly, except July and August.

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PREBLE—John D. Darrow, President, 228 North Barron Street, Eaton 45320; J. R. Williams, Secretary, 228 North Barron Street, Eaton 45320. December yearly.

SHELBY—George J. Schroer, President, 322 Second Avenue, Sidney 45365; Alfonsas Kisielius, Secretary, Ohio Building, Sidney 45365.

Third District

Councilor: Frederick T. Merchant, Marion 43302
1051 Harding Memorial Pky.

ALLEN—T. L. Edwards, President, 670 West Market Street, Lima 45801; T. D. Allison, Secretary, 401 Metropolitan Bank Building, Lima 45801. 3rd Tuesday monthly (omitting June, July, and August).

AUGLAIZE—R. S. Sobocinski, President, 7 South Blackhoof Street, Wapakoneta 45895; J. F. Bowling, Secretary, 319 West Spring, St. Marys 45885. 1st Thursday odd months, with exception of July.

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MERCER—Cecil E. Pennington, President, 406 South Oak, Coldwater 45828; George H. McIlroy, Secretary, 123 East Fayette Street, Celina 45822. 3rd Thursday monthly.

SENECA—Lowell K. Good, President, 133 West North Street, Fostoria 44830; W. F. Yarris, Secretary, 301 Perry Street, Fostoria 44830. 3rd Tuesday every other month.

VAN WERT—Wilmer L. Iler, President, Medical Arts Building, Fox Road, Van Wert 45891; Fred E. Culler, Secretary, 938 South Washington Street, Van Wert 45891. 4th Friday monthly.

WYANDOT—Joseph J. Browne, Acting President and Secretary, 777 North Sandusky Street, Upper Sandusky 43351. 2nd Tuesday monthly.

Fourth District

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3939 Monroe St.

DEFIANCE—George L. Boomer, President, 1075 East Second Street, Defiance 43512; Miss Lois Coffin, Executive Secretary, P. O. Box 386, Defiance 43512. 1st Saturday monthly.

FULTON—F. E. Elliott, President, 203 Beech Street, Wauseon 43567; R. L. Davis, Secretary, 137 South Fulton, Wauseon 43567. Quarterly, March, June, September, and December, 2nd Tuesday.

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LUCAS—George T. Booth, President, 1006 Secor Hotel, Toledo 43603; Mr. Robert W. Elwell, Executive Secretary, 3101 Collingwood Boulevard, Toledo 43610. Council meets on 3rd Tuesday of each month except July and August.

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GEAUGA—C. K. Adrian, President, Medical Arts Building, 13221 Ravenna Road, Chardon 44024; Mrs. Martha Withrow, Executive Secretary, P. O. Box 249, Chardon 44024. 2nd Friday monthly.

LAKE—Wm. C. Downing, President, 150 Mentor Avenue, Painesville 44077; Mrs. Owen A. McLaren, Executive Secretary, 7408 Cadle Avenue, Mentor 44060. 4th Wednesday evening of January, March, May, September, and November, unless otherwise ordered by the Council.

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Councilor: Edwin R. Westbrook, Warren 44481
438 North Park Ave.

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Seventh District

Councilor: Sanford Press, Steubenville 43952
625 North Fourth Street

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COSHOCOTON—Donald E. Potts, President, 600 East Main Street, West Lafayette 43845; H. W. Lear, Secretary, 345 South 4th Street, Coshocoton 43812. 2nd Tuesday monthly.

HARRISON—Charles Evans, President, 159 South Main Street, Cadiz 43907; G. E. Vorhies, Secretary, Seio 43988. 3rd Wednesday, March, June, September and December.

JEFFERSON—Lee A. Rosenblum, President, 114 Brady Circle, E., Steubenville 43952; Raymond B. Cagina, Secretary, 909 3rd Street, Brilliant, Ohio 43913. 4th Tuesday monthly except no meeting in December, January, and February.

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241 Hudson

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4th & Sycamore St.

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HOCKING—Jan S. Matthews, President, 9 East 2nd Street, Logan 43138; J. W. Doering, Secretary, 42 North Spring Street, Logan 43138. 2nd Tuesday monthly.

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MEIGS—Charles J. Mullen, President, 210½ East Main Street, Pomeroy 45769; E. Butrimas, Secretary, 204 East Main Street, Pomeroy 45769. Meetings as needed.

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Tenth District

Councilor: Richard L. Fulton, Columbus 43212

1211 Dublin Rd.

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MORROW—Lowell Murphy, President, 209 South Marion Street, Cardington 43315; David James Hickson, Secretary, 712 Baker Street, Mt. Gilead 43338. 1st Tuesday monthly, 6:30 P. M. dinner.

PICKAWAY—Edward L. Montgomery, President, 213 East Main Street, Circleville 43113; Carlos Alvarez, Secretary, 147 Pinckney Street, Circleville 43113. 1st Friday monthly, except July and August.

ROSS—Richard L. Counts, President, 56 East Second Street, Chillicothe 45601; Walter Kramer, Secretary, 39 West Main Street, Chillicothe 45601. 1st Thursday monthly.

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1749 Cleveland Road

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HURON—Richard L. Jackson, President, 388 E. Howard Street, Willard 44890; John Rosso, Secretary, 218 Myrtle Avenue, Willard 44890. 2nd Wednesday of February, April, June, August, and December.

LORAIN—Robert S. VanDevort, President, 230 Hamilton Avenue, Elyria 44035; Mrs. Gladys Davidson, Executive Secretary, 428 West Avenue, Elyria 44035. 2nd Tuesday monthly, except June, July, and August.

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Five New Medical Schools Open For the 1967-1968 Session

Five new medical schools opened this fall, and others are increasing their enrollments of beginning medical students.

The result is an increase of first-year medical students to an estimated 9,280, compared with 8,964 last year, says *The AMA News*, published by the American Medical Association.

There now are 94 U. S. medical schools in operation. Eleven other new medical schools are continuing development programs including one at Toledo. These developing schools, plus the five just put into operation, are expected to be graduating an additional 1,062 medical students annually by the mid-1970s. Medical schools will then be graduating about 10,000 students annually.

Total medical school enrollment was 82,835 last year, and is expected to increase substantially this year.

The new schools are the University of Arizona College of Medicine, at Tucson; Brown University's Program in Medical Science at Providence, R. I.; the University of Hawaii School of Medicine, at Honolulu; Michigan State University's College of Human Medicine, at East Lansing, and Pennsylvania State University's Milton S. Hershey Medical Center, Hershey, Pa.

Pediatric Training Program In Cincinnati Expanded

A community pediatric program to train practitioners in newer concepts of general pediatrics has been inaugurated by the Good Samaritan Hospital of Cincinnati and the University of Cincinnati Medical Center. The Department of Pediatrics at the 780-bed community hospital is now an educational division of pediatrics in the University's Department of Pediatrics.

The program stresses interactions among the medical, social, and emotional needs of children, their families, and the communities in which they live.

Resident physicians undergo training in three types of hospitals interested in pediatric care: a specialty hospital — 215-bed Children's Hospital; a community hospital for the county's ill, admitting no private patients — 738-bed Cincinnati General Hospital, and a community hospital for indigent and private patients — Good Samaritan.

Dr. Edward L. Pratt is professor and director of the pediatrics department at the University of Cincinnati. Dr. Donald J. Frank, UC assistant professor, is Good Samaritan Hospital director of pediatrics and in charge of the community pediatric residency program.

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Ohio Anesthesiologists Meet in Youngstown; Elect Officers

The 28th Annual Meeting of the Ohio Society of Anesthesiologists, Inc., held a full day of programs on September 16 following the Board of Directors' meeting at the Voyager Inn in Youngstown.

Welcomes were extended by Edward Hartenian, M.D., of Cincinnati, president, Ohio Society of Anesthesiologists and DeForest W. Metcalf, M.D., of the Youngstown Hospital medical staff who was chairman of the annual event and who served as OSA president, 1960-1961.

The program for the day included a discussion of "The Coronary Care Unit" by Charles J. McGaff, M.D., director Coronary Care Unit, St. Vincent Hospital, Toledo; the reading of two resident essay papers; a look at "The Anesthesiologist and the Respiratory Care Unit" by H. B. Fairley, M.B., B.S., of the Department of Anesthesia, director of Respiratory Care Unit, University of Toronto, Toronto, Ontario.

Then following a luncheon, Dr. Edward Hartenian presented scrolls to past presidents of the Society and a message from the president of the American Society of Anesthesiologists was delivered by Nicholas G. DePiero, M.D., Stanley O.

Hoerr, M.D., chairman, Department of Surgery, Cleveland Clinic, addressed the assembly on the subject, "Gall Bladder Surgery in the Patient Who Has Had a Coronary"; the topic of "Anesthetic Management of the Coronary Patient for Gall Bladder Surgery" was discussed by Peter Bosomworth, M.D., professor and chairman, Department of Anesthesiology, University of Kentucky Medical Center, Lexington, Kentucky; and the program concluded with a final discussion "When is the Patient Who Has Had a Coronary, Ready for Surgery?"

Grant Furthers Postgraduate Studies For Ph. D. Medical Educators

The Ohio State University has received a \$76,580 grant from the National Institutes of Health for the inauguration of a fellowship program in medical education.

The project will prepare specialists in the field of medical education and is a cooperative venture between Ohio State's College of Medicine, its College of Education and the Regional Medical Program of the NIH.

Five post-examination Ph.D. candidates in education will receive the fellowships to work on research projects in the health fields.

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Live measles and oral poliovirus vaccines should probably be given separately.

SIDE EFFECTS of significance have not been reported. However, the risk of vaccine-induced poliomyelitis, estimated to be from 1:2,500,000 to 1:50,000,000 should be considered.

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Methyl Testosterone . . . 12.5 mg.
Thyroid Ext. (1 gr.) . . . 64 mg.
Glutamic Acid 50 mg.
Thiamine HCL 10 mg.

Dose: 1 or 2 tablets daily.

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Bottles of 60, 500.

Each white tablet contains:

Methyl Testosterone . . . 2.5 mg.
Thyroid Ext. (1/4 gr.) . . . 15 mg.
Ascorbic Acid (Vit. C) . . . 250 mg.
Thiamine HCL 25 mg.
Glutamic Acid 100 mg.
Pyridoxine HCL 5 mg.
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Indications: Urinary tract infections caused by gram-negative and some gram-positive organisms.

Side effects: Mainly mild, transient gastrointestinal disturbances; in occasional instances, drowsiness, fatigue, pruritus, rash, urticaria, mild eosinophilia, reversible subjective visual disturbances (overbrightness of lights, change in visual color perception, difficulty in focusing, decrease in visual acuity and double vision), and reversible photosensitivity reactions. Marked overdosage, coupled with certain predisposing factors, has produced brief convulsions in a few patients.

Precautions: As with all new drugs, blood and liver function tests are advisable during prolonged treatment. **Pending further experience, like most chemotherapeutic agents, this drug should not be given in the first trimester of pregnancy. It must be used cautiously in patients with liver disease or severe impairment of kidney function.** Because photosensitivity reactions have occurred in a small number of cases, patients should be cautioned to avoid unnecessary exposure to direct sunlight while receiving NegGram, and if a reaction occurs, therapy should be discontinued. The dosage recommended for adults and children should not arbitrarily be doubled unless under the careful supervision of a physician. Bacterial resistance may develop.

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References: (1) Based on 23 clinical papers, 1512 cases. Bibliography on request. (2) Bush, I. M., Orkin, L. A., and Winter, J. W., in Sylvester, J. C.: *Antimicrobial Agents and Chemotherapy*—1964, Ann Arbor, American Society for Microbiology, 1965, p. 722.

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HUGO HECHT, M.D.*

It seems strange that out of the Ghetto in Prague (Austria) came the first private organization of mutual help in case of sickness. In 1771 three inhabitants of the old Ghetto in Prague founded a society which collected monthly contributions and voluntary donations to be able to help the members to pay, in case of illness, doctor's fee, medicaments, the costs of hospital stay and, in case of death, the funeral expenses. The names of these men of remarkable foresight were Simon Busch, Samson Joss and Jacob Katz. They called their society "Dereh Yeshera" (the straight way).

A committee directed all activities of the society. If a member was reported sick, he was visited as soon as possible by an employee of the Society, who saw to it that a doctor was called. In case of need, this doctor could call another doctor for advice at the expense of the Society. The members of the Committee, who were paid for their work, had to visit the patient and stay with him at night when required. A professional nurse was called if necessary and was paid by the Society. Costs of hospital stay were also paid. If the patient needed time and money for recovery after a serious illness, the Society helped him for a certain time until he was able to resume his normal life. In case of death, not only were the costs of the funeral paid by the Society, but if the deceased had no male descendants, the Society saw to it that the ritual prayer for the dead was said each day for the whole year and after this on *every* anniversary of the death.

A similar Society was organized in the Jewish community in Kolin (near Prague) a few years later with a much expanded program. Besides the care of the sick was an old-age pension provided for members older than 60. Even members of the Kolin Jewish community who were not members of the Society got help when needed.

Even though they may have lost much of their usefulness due to the development of compulsory health insurance of workers and employees in Austria at the end of the 19th century, both these insurance groups existed until the occupation of Bohemia by the Germans in 1939.

Literature: Lion, J., and Lukas, J.: *The Prague Ghetto*, London, N. W. 5: Spring Books, pp. 67-68.

*Dr. Hecht, Cleveland, is Consulting Dermatologist, Mount Sinai Hospital of Cleveland.

Submitted November 23, 1966.

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Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently. Large doses of Butazolidin alka are contraindicated in glaucoma.

Warning: If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with great caution in the first trimester of pregnancy.

Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools or other evidence of intestinal hemorrhage occur. Make regular blood counts. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The most common are nausea, edema and drug rash. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. The patient should be instructed to take doses immediately before or after meals or with milk to minimize gastric upset. Mild drug rashes frequently subside with reduction of dosage. However, rash accompanied by fever or other systemic reactions usually requires withholding medication. Purpuric rash has also been reported. Agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome, or a generalized allergic reaction similar to serum sickness may occur and require permanent withdrawal of medication. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

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*Stein, I.D.: Presented at the American Academy of General Practice, Dallas, Sept. 1967.

For complete details, please see full prescribing information.

Special Notice from the Ohio Department of Health

Discontinuance of Kolmer Reiter Protein Test for Syphilis

CHARLES C. CROFT, Sc.D.*, and CALVIN B. SPENCER, M.D.**

THE NOTICE of September 15, 1966 stated that the Kolmer Reiter Protein test would be retained for the immediate future, in spite of its low sensitivity in early and late syphilis. Another year of experience with this test in conjunction with the VDRL and the FTA-ABS has failed to indicate that it serves any useful purpose for the following reasons:

1. The KRP test is slightly less sensitive than the VDRL in secondary and in late syphilis.
2. The KRP test lacks sensitivity in early syphilis.
3. While generally more specific than the VDRL test, it is less specific than the FTA-ABS test.
4. Use of the KRP has not significantly decreased the number of FTA-ABS tests performed.

The figures in the accompanying Table 1 quoted from Moore and Knox, exemplify these statements.

TABLE 1. *Per cent Reactive*

Tests Performed	Primary Syphilis 76 Cases	Secondary Syphilis 100 Cases	Biologic False Positives 38 Cases	Untreated Syphilis, 30 or more Years' Duration 46 Cases
VDRL	50.0	100.0	100.0	54.4
KRP	48.7	91.0	0	43.5
FTA-ABS	80.7	100.0	0	100.0
TPI	36.8	67.0	0	91.2

Therefore, the KRP test will no longer be performed in this laboratory, effective September 1, 1967.

Future Syphilis Serology Regimen Ohio Department of Health

VDRL Slide Flocculation Test

The VDRL test will be applied to all blood sera and spinal fluid specimens.

A NONREACTIVE report excludes active syphilis as well as any standard test. Repeat specimens should

be submitted if early syphilis is suspected or if other clinical or historical evidence of syphilis is present.

A REACTIVE report should be verified by a second specimen when clinical or epidemiological evidence supports the diagnosis of syphilis. If a biologic false positive reaction (BFP) is suspected, also verify by a second specimen.

VDRL Quantitative Test

The quantitative test will be applied without a request to all sera showing any degree of reactivity in the standard test. Titers may be comparable with different serum specimens only when tests are performed in the same laboratory.

Rising titers — Suspect syphilis infection. A four-fold rise is minimal serologic evidence for retreatment.

Falling titers — Suspect BFP reaction in absence of treatment.

Fluorescent Treponemal Antibody Test, Absorbed (FTA-ABS)

The test will not be performed routinely. It must be requested only for problem cases and the request must be supported with minimal information. Place statement(s) of following conditions on accompanying information slip:

1. Early syphilis suspected.
2. If not early syphilis, two previous standard tests on separate specimens have been done within six months preceding.

Do not request FTA-ABS if syphilis has previously been diagnosed or treated, or if FTA has been reported reactive. Do not use as a guide to therapy.

In general, valid requests are for patients suspected of having BFP reactions (no clinical evidence of syphilis) or when standard tests are nonreactive but clinical evidence of syphilis is indicated. BFP reactions may be indicative of other systemic diseases.

NOTE: Pay postage first class when written information accompanies specimens.

Reports — FTA results are probably the best available today for the serodiagnosis of syphilis. The FTA-ABS test is the most sensitive available. However, test results cannot replace the clinical judgment

*Dr. Croft, Columbus, is Chief, Bureau of Public Health Laboratories, Ohio Department of Health.

**Dr. Spencer, Columbus, is Acting Chief, Bureau of Preventive Medicine, Ohio Department of Health.
47:521-524, 1967.

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of the physician. A borderline report means that the results cannot be interpreted as either reactive or non-reactive.

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This test, obtainable from a reference laboratory, should be required in only a very limited number of problem cases where FTA results have not proven helpful in the diagnosis. *Please limit requests.* Use the special collection outfit and history form obtainable from the Ohio Department of Health Laboratory.

References

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OSU Medical Educators Attend Sixth "Retreat" Seminar

The status of physicians in post-M.D. education should be upgraded so that hospital and college appointments will reflect more realistically the qualifications and the teaching and patient care roles of the graduate physicians, according to one of several recommendations made by Ohio State University College of Medicine faculty attending the College's Sixth Annual Seminar in Medical Education. The seminar serves as a "retreat" at which members of Ohio State's College of Medicine faculty can express ideas and problems pertinent to their roles as educators of future physicians.

The three-day seminar involved some 60 members of the faculty and guests, and was held the second week in September. This year, emphasis was placed on ways and means to retain and improve the quality of post-M.D. education at the college.

Other recommendations were: Post-M.D. courses at Ohio State should be opened to qualified physicians from outside the college, by permission, and they should carry academic credit where appropriate.

Regarding community service, members of the seminar recommended that a committee should be established to develop interdisciplinary studies of the organization and delivery of health and medical services, including family practice.

On internship programs, seminar members felt there should be a flexible transition between medical school and post-M.D. education, including conventional straight internships, internships with content largely determined by the intern's interest and the

department of his choice, and direct entry into specialty education.

Graduate degree programs were also discussed. It was recommended that graduate degree programs should have research content with formally structured courses having prerequisites, taught by faculty who are especially trained or experienced to teach at the graduate level. The course content should be oriented to encourage creative scholarship and research, but work would be in addition to the usual residency requirements.

The members of the seminar felt that innovation and experimentation in post-M.D. education should be encouraged, especially at the departmental level, and that teaching skills should be developed in all of the College of Medicine's post-M.D. educational programs.

It was recommended that if possible a seminar be initiated under the auspices of the College of Medicine at Ohio State to include the directors of medical education of community hospitals, community practitioners, and faculty of the college. This seminar should examine mutual concerns in medical education.

The keynote address to the seminar was given by Luvern L. Cunningham, Ed. D., dean of the College of Education at Ohio State. Other guests were Paul Nemir Jr., M. D., associate professor of surgery, University of Pennsylvania School of Medicine, Philadelphia; Robert H. Bruce, Ph. D., dean of the Graduate School, University of Wyoming, Laramie; John C. Nunemaker, M. D., associate secretary of the American Medical Association, Chicago; and Eugene A. Stead, Jr., M. D., chairman of the Department of Medicine at Duke University Medical Center, Durham, N. C.

Status of Cancer Chemotherapy Is Subject of Pamphlet

"Drugs vs. Cancer," a 17-page report on the current status of cancer chemotherapy research, has been issued by the Public Health Service. It is the third in a Research Report series prepared by the Research Information Branch, National Cancer Institute, National Institutes of Health.

The first pamphlet in the Research Report series was "Progress Against Leukemia," published in 1962. The second, issued in 1964, reported on "Virus-Cancer Research."

Single copies of "Drugs vs. Cancer" (PHS Publication No. 1652) are available without charge from the Public Health Service, Washington, D. C. 20201. The pamphlet may be bought in quantity from the Superintendent of Documents, U. S. Government Printing Office, Washington, D. C. 20402 at 15 cents a copy.

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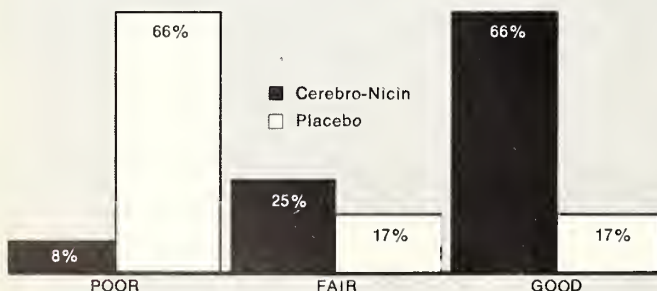
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*A Double-Blind Study of Cerebro-Nicin, Therapy for the Geriatric Patient, R. Goldberg Jrnl., of the Amer. Ger. Soc. June, 1964

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Niacinamide.....	5 mg.
Riboflavin.....	2 mg.
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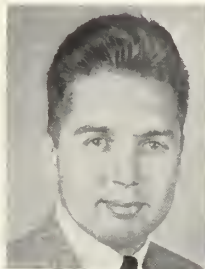
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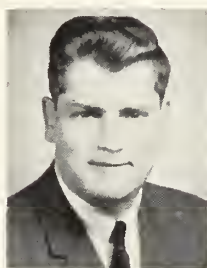
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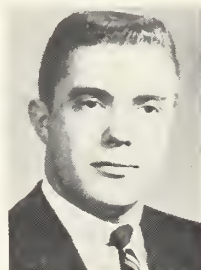
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Drugs — Judgment or Regulation?

EDITOR'S NOTE: Physicians have a considerable stake in the current pressure drive aimed at incorporating into government medical care program compulsory generic prescribing. The following article was written by a top executive in the pharmaceutical industry. *The Journal* presents it as background material for physicians, many of whom may wish to write to their Senators and Representatives expressing their views on this vital topic.

AS WITH MANY IMPORTANT ISSUES today the subject of so-called "generic dispensing" is clouded with a great number of confusing and conflicting statements. Generic prescribing is not new and has been an integral part of prescribing for many, many years.

A drug usually has three names: a chemical name, which has significance primarily to the chemist and other scientists; a generic or public name, which is somewhat simpler and has greater understanding in pharmacology, medicine, and pharmacy; and a trade or brand name which conveys information as to the manufacturer of a particular product. Thus for particular generic drug entities there may exist different brand names, connoting a difference in the method of manufacture, controls at different levels of production, and a history of clinical performance characteristic of that particular brand.

Therapeutic "Identity" Questioned

A pharmaceutical product is more than a drug, and the care, skill, and integrity employed in its manufacture may make all the difference in the performance of that product in a patient. There are those who would have us believe that all products containing the same generic drug are therapeutically identical, but this is not true. The Commissioner of the Food and Drug Administration in recent testimony and speeches has clearly indicated that although he might like to give the assurance that all drug products are clinically equivalent, at this point in time he cannot honestly do so.

A great deal has been made of the fact that the government buys drugs under generic names only. However, if one examines the bid awards, one finds

that an overwhelming majority of products are supplied by brand name manufacturers. In a recent speech, a representative of the Defense Personnel Support Center indicated, "Basically, our problem is this: chemically equivalent items are not necessarily stable, therapeutically equivalent products . . . 45 per cent of the preaward samples submitted by the low bidder last year failed to pass our tests."

Factors to Consider

The truth of the matter is that the technology of understanding drug action, availability, absorption, excretion, binding, partition coefficient, solubility, enzymatic interaction, and a host of other factors is still in its infancy. These are more than mere technical characteristics; they are determinants of therapeutic performance. Thus the history of experience by the physician and pharmacist and the integrity of the producer to produce drugs which result in consistently reproducible action is the most reliable guide available at this time. Any effort to remove the prescription decision from the physician and substitute some government constituted authority, is a dangerous proposal which could be detrimental to the health of the patient and a serious blow to high quality medical care in this country.

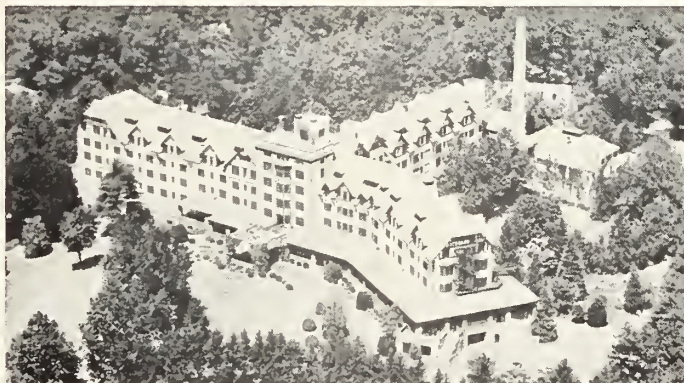
The number of products for which generic prescribing might result in savings for the patients represent less than 20 per cent of the total number of prescriptions dispensed annually. In some of these instances the real savings are relatively insignificant. The proposed savings that are supposedly available have been wholly exaggerated. In the majority of instances of generic prescriptions, it has been the policy of most pharmacists to dispense only those products which experience has shown to be therapeutically reliable — generally a branded product.

The Ultimate Responsibility

The physician, who has the ultimate responsibility for the treatment of the patient, should be constantly aware of the drug products prescribed and dispensed for his patients. He can on occasion, by consulting with his pharmacist, select products in which a degree of confidence can be assured with some cost savings resulting. However, an understanding of all parameters involved is essential. There have been too many instances where patients on maintenance therapy with such drugs as anticoagulants are hospitalized and

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Regardless of the advancement of our scientific information, a great deal of the practice of medicine and of pharmacy involves the use of professional judgment. Any artificial barriers which interfere with the exercise of this judgment are unwise and dangerous. The physician should be free to prescribe the products which he deems best for his patients. Any changes in the medication should only come about after proper consultation between physician and pharmacist and only effectuated with the consent of the physician. Those who seek other approaches should make certain that they are fully aware of the consequences that may result and determine whether the risks involved are truly worth the savings. In the best interests of public health, we do not believe that they are!

Major Medical Insurance Benefits Reach All Time High for Year

Americans used benefits from insurance company major medical expense insurance to pay for over \$1.2 billion of their health care bills last year.

This set a record for benefits paid by this type of insurance, and for the second straight year it exceeded a billion dollars, the Health Insurance Institute reported.

At the end of 1966, over 56.7 million persons were covered for major medical expenses under insurance company group, individual or family policies.

This included nearly 55.5 million persons under 65 and nearly 1.3 million 65 and over. It was an overall increase of more than five million from the previous year.

Group policies covered 52 million of these persons, while nearly five million were under individual or family policies.

About 1.1 million persons 65 and over and eligible for Medicare were maintaining group coverage, the Institute said.

With benefits up 12.4 per cent from the 1965 total, major medical insurance continued to be the fastest growing form of health insurance in the United States.

Since it became generally available in the early 1950's, it has been growing at a rapid pace.

At the end of 1951, for example, only 108,000 persons were protected under these policies. Ten years later, over 34 million were insured.

Today, over one-third of all persons with private health insurance have insurance company major medical insurance, said the Institute.



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Grant Supports Western Reserve Program in Advance Sciences

To educate medical investigators with an in-
creased potential for making contributions to the
knowledge of nature and control of disease, a new
Ph.D. program has been initiated by the Depart-
ment of Pathology of Case Western Reserve Uni-
versity School of Medicine.

The program began with eight students at the
start of the current academic year. Chosen because
of special aptitude and skills for advanced scientific
study, the students will get five or six years' advanced
work in one of the physical sciences (chemistry,
physics, mathematics) or one of the basic medical
sciences, biology, biochemistry, physiology), along
with graduate work in pathology.

Although about a dozen medical schools in the
country now offer an advanced curriculum in
pathology leading to the Ph.D. degree, the Case
Western Reserve program is unique in at least two
respects, officials report.

It offers more rigorous training in the physical
and biological sciences than do other pathology
departments. It is also more flexible than other
graduate pathology curricula in that the student may
combine two or more of the other sciences to earn
the new pathology degree; his program will be
tailored to his individual talents, previous training,
and interests.

The intent, as explained by Dr. John R. Carter,
director of the Case Western Reserve Pathology De-
partment who designed the new curriculum, is to
broaden the range and knowledge of future pathol-
ogists by providing them with the insights that
can be added by the physical sciences.

To start the new pathology program here, the
National Institute of General Medical Sciences has
awarded a grant of \$800,000 to Case Western Re-
serve University School of Medicine for the first
five years. Most of the funds are to be used as
fellowship grants to the students.

Eight students are now enrolled as fellows for
the 1967-68 academic year; five with M.D. degrees,
one with a Ph.D. in chemistry, and two with B.S.
degrees who will work toward their first graduate
degree, a Ph.D. in pathobiology. The five M.D.'s
are working for Ph.D.'s in pathobiology, biochemistry,
chemistry, and mathematics.

Four more students, who recently earned their
medical degrees, have already applied for fellow-
ships in the next, 1968-69 academic year. Alto-
gether, 14 fellows will be enrolled next year, 16
the following year, and 20 each year thereafter.



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Moving Ahead in Public Health...

Address by State Health Director Before Annual Conference Of Ohio Health Commissioners Outlines Activities for Year

PROGRESS in the Ohio public health field was reported by Dr. Emmett W. Arnold, director of the Ohio Department of Health, before the 48th Annual Conference of Ohio Health Commissioners with the Ohio Department of Health, on September 13 in Columbus.

The annual conference, an official state function, was held in conjunction with the annual meeting of the Association of Ohio Health Commissioners, a voluntary society.

Ollie M. Goodloe, M.D., Columbus, was installed as president of the Association of Ohio Health Commissioners. Harry Wain, M.D., of Mansfield, was named president-elect, and Allen Greenlee, D. V. M., of Newark, was elected secretary-treasurer.

Robert E. Howard, M.D., Cincinnati, President of the Ohio State Medical Association, addressed the group, using as his theme, "Public Health and Our Changing Times." Dr. Howard stressed the importance of close cooperation between physicians in all walks of professional activity and public health teams. He especially commended the health commissioners for dedicated performance in health departments on state and local levels, and referred to an orientation session he himself had in public health matters before he assumed his office as OSMA President.

* * *

Following are excerpts from Dr. Arnold's address to the health commissioners.

The theme for this annual report to you might be summarized in just two words: Moving Ahead.

Public health is moving ahead in Ohio—steadily, vigorously. Our efforts are resulting in gains over a broad front, some slight but many spectacular. The state of the State's health is good. Preventive steps for health protection are functioning well. Programs for broad-scale improvement in the general well-being of individuals are taking effect. Environmental health hazards are being attacked and reduced.

Local health departments in Ohio—city and county departments—expended more than \$19.5 million on their programs in fiscal 1967. This is a gain of over \$2 million from the previous year and \$3.5 million higher than in 1965.

The support and strengthening of local health departments is a main purpose and principal respon-

sibility of the State Health Department. We are encouraged and pleased by the growth of local health departments and the expansion of their services.

The present Ohio General Assembly has offered means for further strengthening of local health department activity by clarifying laws on mergers, combinations and contracts among local departments.

We in the Ohio Department of Health have been very pleased with the new acts of the Ohio General Assembly. We feel that public health has fared well at the hands of the legislators.

We are particularly pleased with the three pieces of major legislation which lay the necessary groundwork for a concerted attack on our biggest problems in the field of environmental health.

These are: (1) Establishment of an Air Pollution Control Board in the Department of Health, with Statewide authority; (2) A solid wastes disposal law, authorizing the Ohio Public Health Council to set up regulations on refuse and garbage disposal for all of Ohio; and (3) A series of amendments strengthening our Water Pollution Control Law.

The Legislature has clearly reinforced the hands of the Water Pollution Control Board to ban construction in areas not served by adequate sewage facilities.

Certain administrative procedures of the Water Pollution Control Board have been simplified, which will speed enforcement action. And a sixth member has been added to this Board—the Director of the Ohio Department of Agriculture.

The new Air Pollution Control Law will be similar in many ways to the Water Pollution Control Law. There will be a five member Board—including the Directors of the Department of Health and Department of Development, and three appointive members to represent municipalities, industry, and agriculture. Violations of the law will be punishable with fines up to \$500 a day. The Board will issue permits and make orders, sponsor research and investigation, and maintain an air monitoring system.

Among this new Board's first responsibilities will be to hold a series of hearings for the setting of ambient air quality standards.

In its legal authority, the Air Pollution Control Board is charged to consider injury or harm to health or welfare, plant or animal life, or property—or

any unreasonable interference with the comfortable enjoyment of life or property.

Municipal governments, incidentally, will still have the right to adopt local ordinances or regulations for air pollution control, if they wish — so long as these are at least as strict as State requirements.

The new Solid Wastes Disposal Law will not take full effect for a year. In the meantime, regulations will be adopted by the Ohio Public Health Council.

Starting January 1, 1969, facilities for the disposal of solid wastes will have to be licensed, with fees running up to \$500. These fees will cover necessary health department inspection and supervision.

In a general way, this program will be comparable to the food service program. Inspection, supervision, and licensing will be handled by local health departments with the approval of the State Health Department.

As we said a moment ago, these new enactments will give us a firm foundation for a concerted attack on environmental health hazards. These hazards are interrelated. Improper solid wastes disposal, sometimes called "the third pollution," can contribute to air and water pollution. Air and water pollution contribute to each other and also may create solid wastes problems. It is important that the attack on the three problems be integrated.

With respect to the food service program, itself, the Legislature has boosted the fine for violations from \$10 to \$100.

While the Legislature's attention seemed to be primarily on environmental problems in the health field, it did concern itself with other matters, including disease control. Two bills particularly are aimed at the tuberculosis patient who refuses proper care and becomes a menace to the community. Local health departments are given the authority to order the medical examination of tuberculosis suspects. And courts are given the authority to hold probate hearings on the commitment of recalcitrant patients in the absence of suspects who refuse hospitalization.

The Legislature formalized the transfer of the operation of the Ohio Tuberculosis Hospital to Ohio State University, an arrangement which we had worked out contractually earlier this year. The State Department of Health retains the authority to determine the number of beds necessary for the tuberculosis control program, as we had requested.

Turning from Legislation, I should like to bring attention to some other areas in which public health has been moving ahead.

Immunization

One of these is measles immunization. Under a Public Health Services grant about a year ago, we were allotted 200,000 doses of the new live virus vaccine and personnel to assist in a promotion and

Revised Birth, Death, and Stillborn Certificates Being Issued

As pointed out in the State Health Director's report to the Health Commissioners' Conference, the 1967 decennial revision of the standard birth, death, and stillborn certificates will be implemented in January, 1968. Old forms will be unacceptable for use after January 31, 1968.

Distribution of the new forms is planned for November and physicians who do not receive a supply of the new forms are advised to contact their local health commissioners. Unused old certificates in the hands of physicians, hospitals, funeral directors, and local health departments should be destroyed not later than January 31.

distribution program. That allotment has been distributed and used. Adding to that the number of immunizations by physicians in private practice, it is our estimate that 381,000 measles-susceptible children have been immunized in the past year.

We have approval for continuation of this project and have another 200,000 doses of measles vaccine available. There is still much to be done in this program. About 185,000 children will be born in Ohio in the next year. Add to that the number of preschool children who were not reached in last year's immunization program and we have a total of about 400,000 who still need this important protection.

That the program is effective is indicated by a sharp drop in measles cases nationally and in Ohio. There were more than seven times as many cases of measles in Ohio in the first quarter of 1966 as in the first quarter of 1967 after this program was under way.

Our communicable disease experts have a growing concern about polio which was pretty well whipped by the Salk and Sabin vaccines. However, there is a growing mass of children who are not protected. They would be susceptible to a brand new epidemic of this much-feared disease. To close this gap in polio immunization, we have available 200,000 doses of oral tri-valent polio vaccine which will be distributed along with the measles vaccine.

We are continuing our close surveillance on the California type of insect-borne virus encephalitis.

VD Control

Our venereal disease control activities — a combined effort of local health departments, State Health Department, and U. S. Public Health Service — are showing results in significant decreases in reported cases of primary and secondary syphilis in virtually all areas of the State. Efforts will be concentrated in

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problem areas in the next year. Of the 21 Public Health Service assignees working in the Ohio VD Program, 10 will be assigned to one city in the coming fiscal year (Cleveland).

We believe that an important factor in reducing the number of infectious syphilis cases is the progress being made in stimulating private physicians and clinicians to administer prophylactic treatment to contacts of infectious cases or suspects even though these contacts may be clinically and serologically negative on initial examination.

In our rheumatic fever prevention program, over 33,000 now are listed in our rheumatic fever registry, and some 21,000 are receiving drug prophylaxis. We are noting an annual addition to the registry of about 3,000 new cases.

With the support of our laboratories and the local heart associations, our Chronic Diseases Division is helping the larger cities to develop or enlarge their own strep throat culture services. For the remainder of the State, we have cooperative agreement with the local health departments, medical societies and heart associations for use of our State Health Department laboratories.

This is another area where we are moving ahead. Five large cities and 21 counties now have Group-A-Streptococcal throat culture services in operation—in addition to our State laboratory services.

Our Department's throat culture kit has been improved and modernized. It easily fits into a physician's pocket or bag and includes an envelope for immediate mailing with a five cent stamp. Twenty-four hours after it arrives at the Laboratory, positive Group-A Beta Hemolytic Strep cultures are reported by telephone to physicians. Follow-up reports in all cases are sent by mail.

About three per cent of Group-A-Strep throat infections are followed by rheumatic fever if untreated.

Cancer Registry

In our cancer control program, a survey of hospital-based tumor registries has been completed. Activities are under way to upgrade existing registries and establish new ones where needed. One-day refresher seminars for tumor registry secretaries are being held around the State. A training course for new tumor registry secretaries is being planned for Ohio State University, College of Allied Medical Sciences.

In another phase of our cancer program, cervical cytology and breast examination programs are being conducted in health department venereal disease clinics, at Planned Parenthood, and family planning clinics, and in hospital out-patient departments. In one project, a field test is being made of a "do-it-yourself" pap smear technique, using a cytopipette which is mailed in by the patient.

Our diabetes detection program reached 34,451 in the past year.

Our staff has been cooperating with the Central Ohio Diabetes Association in development of a camp, somewhere near Columbus, for juvenile diabetics.

In the field of alcoholism, we are moving ahead. With grant monies made available by the 106th General Assembly, we have supported 33 local alcoholism projects in the past year.

The Ohio Education Program on Smoking and Health is gaining attention.

Turning to the field of dentistry, our reports show that nearly 275,000 school age children in Ohio received dental examinations last year through the activities of local health agencies. Of this large number examined 44,789 received some remedial treatment. Another 11,000 received topical application of stannous fluoride to help retard dental decay. Our own unit conducted special programs in 17 counties.

One Ohio community, with a population of 5,400, joined the group providing community fluoridation of water supplies during the past year. There are 128 others in the State. At this time, about 43 per cent of Ohioans served by municipal water systems have water with the optimum fluoride content for the development of healthy, strong teeth.

Ohio now ranks 27th among all states in terms of the percentage of population using water with the optimum amount of fluoride.

The new Health Referral Service, designed for persons rejected for military induction because of health reasons, has had a tremendous acceptance in its first year of operation. Contracts have been formalized with 144 local health jurisdictions for follow-up service. This covers approximately 97 per cent of the population of the State.

We have seven nurse-counselors at the three armed forces examination stations in Cleveland, Columbus, and Cincinnati, especially trained for this program.

The importance of this program is found in the statistics. During calendar year 1965, latest for which complete figures are available, 40 per cent of pre-induction examinees were disqualified for military service—and 27 per cent of these for medical reasons.

Ninety-one per cent of the rejectees accepted counseling under the Health Referral Service. And 47 per cent of these were referred to the local level for follow-up services. The others were either under medical care or had their own plans.

Medicare Unit

Another new unit in our Department which got into operation smoothly last year is our Medicare Unit for the certification of hospitals, extended care facilities, independent laboratories, and home health services for participation in the Federal medicare program. This unit last year participated in the certification of 255 Ohio hospitals, 160 extended care fac-

ilities, 76 independent laboratories, and 101 home health services. The unit is now involved in the second stage which involves re-survey and re-certification.

With reference to the home health agencies, an area in which we had special concern and to which we gave a considerable amount of attention before the program got under way last year, we find that approximately 85 per cent of the population of Ohio is covered by the 101 agencies that have been certified. And you will be interested in the fact that 65 per cent of these agencies are in health departments. We must note, however, that there still are 21 counties which are not provided with home health services.

As you may have noticed, I already have made several references to laboratories and laboratory services. Our Department can move ahead at any time only with a corresponding progress by our Bureau of Laboratories. This part of our Department has expanded its services in many areas. One new phase is the survey work, just mentioned, in connection with medicare certification of independent laboratories. Another is in the streptococcus grouping in the rheumatic fever program, a service which doubled in 1966 over 1965 and then quintupled in 1967. Encephalitis serologic tests revealed 37 cases of California type in 1966.

The tests on infants for phenylketonuria reached a total of 154,394 last year—with 11 infants diagnosed as being phenylketonuric and needing special diets to prevent mental retardation.

In addition to the work on disease entities, our laboratories are having an increased responsibility in connection with environmental health—sanitary and industrial chemistry. This work obviously will increase with the new air pollution control program and with the expansion of monitoring and surveys in water pollution control.

In this connection, on July 1, 1967, our Division of Sanitation and local health departments inaugurated a program aimed at the control of abnormal raw milk. This program consists of eight laboratory examinations annually for the presence of unwholesome, altered mammary secretions. The tests will be run by an Ohio Department of Health approved laboratory. Producers will be notified of all test results.

Nursing Services

Expanding health programs demand an expansion of public health nursing services, too. Last year, our 10 generalized nursing consultants made more than 900 visits to local health departments and nursing services to offer assistance in meeting these demands. Ohio has approximately 1,700 nurses employed by health departments, visiting nurse associations and schools. It is estimated that this is only about half as many as are really needed for our population of nearly 11 million.

One hopeful sign is that funds are becoming more readily available for nursing services through the

Federal health insurance programs and through special projects for health services such as migrant labor, chronic disease, tuberculosis, and maternal and child health. It is encouraging to see agencies gradually adding to staffs as these funds become accessible.

There is still, however, a shortage in availability of active nurses. One new suggestion is the employment of nurses in public health agencies on a part-time basis.

In the past year, our health education consultants have worked locally with a total of 59 health departments on such projects as diabetes screening, migrant and school health programs, compiling and revising health directories. Our Creative Services Unit completed 127 special work requests for local departments. And we distributed 6,274 films for local use.

Our Training Unit has been involved in recruitment, refresher training, and efforts to induce various inactive professionals back into active public health work—dietitians, technicians, and others as well as nurses.

Nutrition has been raised to division level in the administration of the State Health Department. We have a new chief for this division—Miss Joyce Kline, who recently received her doctor's degree in education.

Migrant Health Program

Those of you from northwestern Ohio especially will be interested to know that migrant health service projects have been expanded and now are projected for approximately a quarter million dollars. To conform with new Federal housing regulations for migrant labor, a system of certification for camps is being developed.

Two pieces of legislation on vital statistics will be of interest to you. One authorizes local registrars to issue certified copies of vital records.

This legislation also provides that information contained in the confidential portion of the birth certificate shall not be included on certified copies, except to an individual requesting the information from his own birth certificate, or by an agency of the Federal, State, or local government charged by law with the duty of detecting or prosecuting a crime.

Another new law pertains to the issuance of new birth certificates for correction of errors.

The 1967 decennial revision of the standard birth, death, and stillborn certificates will be implemented in January of 1968. Distribution of the new forms is planned for November of this year. Unused old certificates still in the hands of physicians, hospitals, funeral directors, and local health departments at

(Continued on Page 1454)



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Contraindications: Barbiturates should not be administered to anyone with a history of porphyria, nor should they be given in the presence of uncontrolled pain, because excitement may result.

Warning: May be habit-forming.

Precautions: Tuinal should be used cautiously in patients with decreased liver function, since prolongation of effect may occur.

Adverse Reactions: Idiosyncrasy, such as excitement, hangover, or pain, may appear. Hypersensitivity reac-

tions occur in some patients, especially in those with asthma, urticaria, or angioneurotic edema.

Overdosage: C.N.S. depression. **Symptoms**—Depression of respiration and of superficial and deep reflexes, slight constriction of the pupils (in severe poisoning, dilation), decreased urine formation, lowered body temperature, coma. **Treatment**—Symptomatic and supportive (gastric lavage; intravenous fluids; maintenance of blood pressure, body temperature, and adequate respiration). Dialysis may speed removal of barbiturates from body fluids.



Dosage: 50-200 mg. ($\frac{3}{4}$ -3 grains) at bedtime.

[031767]

Additional information available to physicians upon request.
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the end of the year should be destroyed since they will be unacceptable for use after January 31, 1968.

Packaged Disaster Hospitals

Another major change under way at this time is the handling of the Packaged Disaster Hospitals in the Emergency Medical Stockpile Program. This is the result of a lengthy study by an Emergency Health Preparedness Task Force. All Packaged Disaster Hospitals will be brought into an operational affiliation with existing community hospitals. An additional 30-day back-up supply of critical medical items necessary for an emergency will be placed in the hospitals taking part in the program.

We have 127 Packaged Disaster Hospitals in Ohio at the present time. Many of these will have to be relocated. So far, 19 community hospitals have signed agreements for affiliation under the new program. For a hospital to be eligible, it should have at least 50 beds and be located within 50 miles of the central city in the Standard Metropolitan Statistical Area. The specific vulnerability of each hospital also will be considered.

One final report—also on the theme of moving ahead in public health—Hill-Burton grants for construction of local health centers have been approved in the past year for Montgomery County, Belmont County, Harrison County, Cincinnati, and Cleveland. Previously approved health centers are nearing completion for Lorain County, Clark County, Defiance, and Akron. Applications for health center grants are currently on file from Perry and Jackson counties. We would welcome more applications in the expectation that additional Hill-Burton funds will be available.

Steubenville Physician Honored By the Italian Government

The Republic of Italy has bestowed the Cross of Chevalier of Merit on Dr. D. A. Macedonia, M. D., of Steubenville for his "professional, church, and civic leadership in fostering better American-Italian community relations."

Michele Bianco, Italian consular agent in Steubenville, announced the honor bestowed on Dr. Macedonia.

The honor is one of a series received by Dr. Macedonia in past years. He was named a knight commander with a star in the Order of St. Gregory the Great by Pope Pius XII in 1952. He was awarded the Caritas Medal by Most Rev. John King Mussio, bishop of Steubenville, in 1955. The Steubenville Dramatic Club in 1950 presented him with the outstanding citizens award. In 1951, Alpha Phi Delta named him "most outstanding alumnus."

He is past national president of Alpha Phi Delta Fraternity; a member of the board of advisers of the College of Steubenville; chairman of the medical advisory board of the Ohio Lions Eye Research Foundation; a past president of the Lions Eye Foundation; past district governor of Lions; a member of the Ohio State Medical Board and Steubenville Board of Health; a member of the Catholic Central Athletic Board.

Dr. Macedonia is honorary president of the Italian-American Cultural Club. He is chairman of the Jefferson County Democratic Party organization.—Adapted from the *Steubenville Herald*.



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PHYSICIAN AND HOSPITAL EQUIPMENT



Scientific Section

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The Physician, the Placebo And the Placebo Effect

FRANK GELBMAN, M. D.

PLACEBO is usually defined as (1) a control used in an experiment, and (2) something tending to sooth or gratify. These uses imply intention and planning.

Most physicians think of a placebo as a deliberate use (by some physician) of an inert substance or procedure which is not related to supposed cause and thought by the patient to be potent.

My presentation will emphasize the effect and influence of the physician—often without his deliberate intent and more often without his awareness. In a grossly oversimplified way, I shall state that the physician is the placebo and the placebo effect comes from the physician.

Perspectives in Placebo Studies

This is a vast subject that can be studied in many different ways.

1. *Looking at Ourselves.* This has the flattering aspect that we physicians are the most important part of the practice of medicine. At the same time, it reminds us that there is so much that we do not know.

2. *A Study of Research Design, Methodology, and Statistics.* In studying reports in journals, we must remember that diagnostic accuracy and reliability are open to question. For example, cardiologists do not always agree on the interpretations of electrocardiograms, roentgenologists do not claim

The Author

● Dr. Gelbman, Youngstown, is Psychiatrist, Youngstown Hospital Association.

complete accuracy in all chest plates or gastrointestinal series, pediatricians disagree regarding the nutritional status of children. Reports in journals imply that the studies were impersonal, mechanical, and coldly scientific—this is impossible when people are involved.

One of the diagnostic problems confronting physicians is similar to that of physicists—that is, the observed changes while under observation.

The double blind study is open to errors. Is the study known to be using a placebo or two different forms of an active drug? Are the subjects and the staff being paid? Is it known that an experiment is in progress? What are the staff attitudes to the study or experiment? Are there side effects to the drug? How long a base line before studies began? How evaluated? How long was the study? What kind of follow-up?

3. *History.* Fine and respected physicians of previous centuries have used harmless and dangerous drugs and procedures, yet helped and cured many of their patients. We have seen our own therapies discarded or seriously questioned during our medical

careers; for example, vagotomy, the use of anti-coagulants, steroids as magical drugs, various anti-rheumatic drugs, the suspension of many organs in the abdominal cavity.

4. *Sociology and Anthropology*. Many of you have had the sad experience, while in military service in some foreign land, of treating natives and obtaining unsatisfactory results with the same therapies used more successfully on our servicemen.

5. *Philosophy*. We easily conclude that an improvement in a patient is a result of some specific therapy that we have used (post hoc, propter hoc). The tolerance of uncertainty is low among all humans.

We know that treatment with a certain drug or procedure will not have the same result on patients with identical diagnoses.

The precise origin of the following truth is not known: You should treat as many patients as possible with the new drugs while they still have the power to heal.

6. *What Is "Science"?* In all likelihood, many of our "scientific" methods will have the same fate of "scientific" methods of past years—rejection or gradual disappearance or partial acceptance.

7. *What is "Pain"?* There is far more to pain than can be explained by neurological arcs.

8. *Psychosomatic Medicine*. Unfortunately, this term implies far too much psychic and too little somatic. Often, the acceptance of the indivisible oneness of the patient means forgetting the physician's relationship with the patient.

The Placebo and the Psychiatrist

Before I proceed, I wish to make it perfectly clear that psychiatrists do not have the answers regarding placebos and the placebo effect. Placebo effects definitely enter into what psychiatrists do.

Some double blind studies question the effect of tranquilizers, antidepressives, and electric shock therapy. Other studies prove that these are far more effective than placebos.

What about psychotherapy? Most psychiatrists agree that the results of psychotherapy basically depend upon the personality of the psychiatrist. Of course, a personality functionally exists only in relation to another personality.

Studies of the results of psychotherapy indicate that similar responses are obtained regardless of school of thought (Freud, Adler, Jung, existential) or variations within the schools. Brief psychotherapy (10, 20, 30 visits) produce similar results to long term therapy (100, 200, 300 visits). Visits of 20 or 30 minutes may be as productive as the 50 minute visit.

An Attempted Explanation

The ready answer is that the physician unconsciously symbolizes the good parent who will make things right and who gives both protection and care. This certainly does not totally account for the placebo effect.

Patients come to the physician for the relief of physical and emotional distress. The physician relieves distress even when his activities appear unrelated to cause. The patient desires help—he sees himself as receiving help. You have often seen your patients respond favorably to studies.

We must remember that suffering is an attempt to cope. The physician's recognition that the patient is suffering, his interest, his attention, his desire to help, often bring the patient to a better level of homeostasis. The patient who gives up apparently does not suffer—then, dies. A wise surgeon is very reluctant, at most, to operate on an apathetic patient who expresses certainty that he will not leave surgery alive.

Many patients have a desire to please and impress their physicians. This is particularly significant in some medical centers.

The setting has an important placebo effect. I am certain that surgeons often have the difficult decision regarding patients who obviously have an acute abdomen in the office or emergency room and improve after admission to the hospital. In our lifetimes, hospitals have a placebo effect that they formerly did not have.

I doubt if physicians in famous medical centers are that much more skilled, if at all, than physicians throughout the country. We are all familiar with many patients who recovered after treatment or study in some well known center. These centers have created an "edifice complex."

Placebo Reactors

It is extremely doubtful if a "placebo reactor" personality exists. People respond to a total situation not the placebo. Everyone is a potential placebo reactor in a given situation. Active drugs always act, in part, as placebos. Often, people with the most initial distress respond most to a placebo.

I do not believe there is a specific personality type that responds to a placebo or who develops a definite so-called psychosomatic disorder (ulcer, colitis, hypertension, migraine, etc.).

Some Causes of the Placebo Effect

Physicians usually think of the patient with little consideration of the physician and the setting. These causes cannot be separated.

1. *The Setting*. Knowledgeable physicians determine where the research was done, even before reading the summary. For example, knowing which

centers are chiefly physiologically or psychologically oriented, psychiatrists automatically know that reports on drug effects, even with double blind studies, will be low with high placebo effects from hospitals which emphasize psychotherapy and quite different from those using physiological therapies.

2. *The Physician.* Physicians often are not aware that the patient evaluates the physician. The placebo effect of the physician is part of the doctor-patient relationship. Please remember that the doctor is first.

The physician's enthusiasm and optimism has a tremendous direct effect on the patient. The patient's response infects the physician producing a happy and productive cycle.

The physician's pride and pleasure in his work plus a positive self-image affects patients. Apathetic, hostile, unenthusiastic workers produce poorer results. The wise chief of any clinical research project inspires his associates.

Physicians who are able to communicate (both nonverbally and verbally), their interest, concern, and liking get better results. The physician's prominence to the patient is important. The age of the physician has significance—many of us are old enough to have experienced variable responses to different patients.

The physician is the therapeutic agent. His medical degree may be his most potent therapy. The physician will always be more important than the hospital or the pharmacy and will remain most important in spite of scientific achievement in medicine.

When the physician believes that recovery or improvement is the result of some activity and effort on his part, patients tend to respond. Faith and hope are not reserved solely for the patient.

3. *The Patient.* I shall deliberately underemphasize the significance of the patient. When a patient responds favorably to a therapy, the physician concludes that therapy was the cause—not his total interaction with the patient. When a therapy fails, the

physician finds fault with the therapy, the patient, then himself—not the doctor-patient relationship.

Practically all the forces said to come from the patient can have their source from the physician—for example, high patient expectancy, hope, faith, harmony with the physician. The alert and wise physician encourages the patient's faith in his own capacities. The patient's previous experience with physicians and his image of physicians have a powerful effect. Intelligent and educated people with negative attitudes to physicians often turn to quacks.

Patients are influenced both by word of mouth and mass communication. "Research" has such magic that a hospital staff not doing research (good, bad, or indifferent) is too easily thought to be a poor staff and the hospital to be substandard.

Summary

The physician is the most important part of therapy.

The results of any therapy depend upon the physician first; then, the what, how, where.

The acceptance of the significance of the physician will lead to neither the underutilization of scientific therapy nor to the overlooking of disease. It will make total therapy more effective.

The placebo effect is present in all therapies.

The placebo effect comes from the total doctor-patient relationship. This basic relationship determines the results of all therapies.

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INSULIN RESISTANCE.—Two Nigerian diabetics who developed resistance to insulin, following the cessation of its administration for some time, are described. In *vivo* and in *vitro* experiments in rats revealed a high level of an inhibitory factor in their sera, compared with sera from various controls. In the two patients the administration of prednisone for ten days was followed by a lowering of their resistance to insulin seven and twelve days later. Chlorpropamide was ineffective in one, and in both a change of the source of insulin was also ineffective. —B. Kwaku Adadevoh, M.B., M.R.C.P., and D. A. Olatunbosun, M.B., B.S., Univ. of Lagos Medical School, Nigeria: *Ghana Medical Journal*, 5:12-16 (March) 1966.

Use of the Shaldon Percutaneous Catheter for Hemodialysis

WARREN W. SMITH, M.D.

THE DEVELOPMENT of disposable parts for the artificial kidney has greatly reduced the practical difficulties of hemodialysis,¹ which now should be in the armamentarium of every hospital undertaking to provide definitive care for very sick patients.² However, before a patient can become "connected" to the "artificial kidney," it is necessary to insert two cannulas into major blood vessels, to serve respectively as a source and return for blood drawn through the dialyzer. In 1961, Shaldon³ devised a catheter which could be inserted by the Seldinger percutaneous technique.⁴ Two of these catheters would be inserted through one femoral vein and one femoral artery,⁵ or both catheters would be inserted into the femoral veins, and these served very well to carry blood from, and return it to, the patient. Other workers⁶⁻⁸ confirmed the usefulness of this new technique.

However, percutaneous catheterization for hemodialysis seems not to have enjoyed the wide acceptance that it merits. It is the purpose of this com-

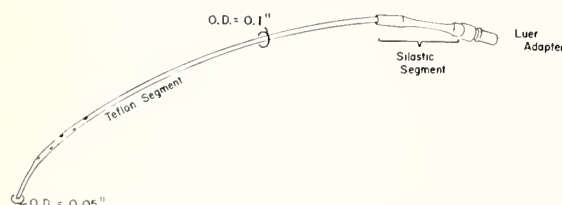


FIG. 1. Schematic representation of the Shaldon catheter. For further details see text.

munication to describe our highly satisfactory experience with this technique, which we believe to be the *method of choice* in certain types of patients.

Description of the Catheter

The catheter devised by Shaldon (Fig. 1) is available commercially at modest cost from the manufacturer in England.^a The main shaft of the cath-

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ter is Teflon®, 30 cm. long, outside diameter 2.5 mm. (approximately the size of a 13 gauge needle), internal diameter 1.6 mm. The shaft is tapered at the tip, and near the tip are 5 "eyes" about 1.2 mm. in diameter and 1 cm. apart from each other. (The cross-sectional dimensions of this catheter are compared with those of certain other catheters and needles in Fig. 2.) To the outer end of the catheter is bonded a segment of silicone rubber, and to this, in turn, is secured a female Luer adaptor. The silicone segment allows for clamping, as Teflon would be permanently indented. The choice of Teflon for the shaft of the catheter provides the many advantages of this material: its nonreactivity and therefore its relative freedom from thrombogenesis, its stiffness, and its slipperiness. The last two properties greatly facilitate percutaneous insertion.

Technique for Insertion

About an hour prior to insertion of the catheters, the patient is premedicated with an intramuscular injection of 100 mg. of chlorthalidone hydrochloride (Librium®), and 50-100 mg. meperidine. Both groins are shaved as if for inguinal herniorrhaphy. The femoral artery pulse is palpated at the point where it passes under the inguinal ligament. This pulse may be felt through a 2 inch course in thin patients, or at just one point in obese or edematous patients. The femoral vein is immediately medial to the pulse of the femoral artery. After disinfectant has been applied to the skin, the tissues immediately overlying the femoral vein are infiltrated with lidocaine (Xylocaine®). A specially made

(a) Watson-Marlow Shaldon Catheter available from Watson-Marlow Ltd., Marlow, Buckinghamshire, England. Cost \$3.50 each in dozen lots, air mail delivered.

Submitted April 3, 1967.

For reprints, write 1211 Dublin Road, Columbus, Ohio 43212.

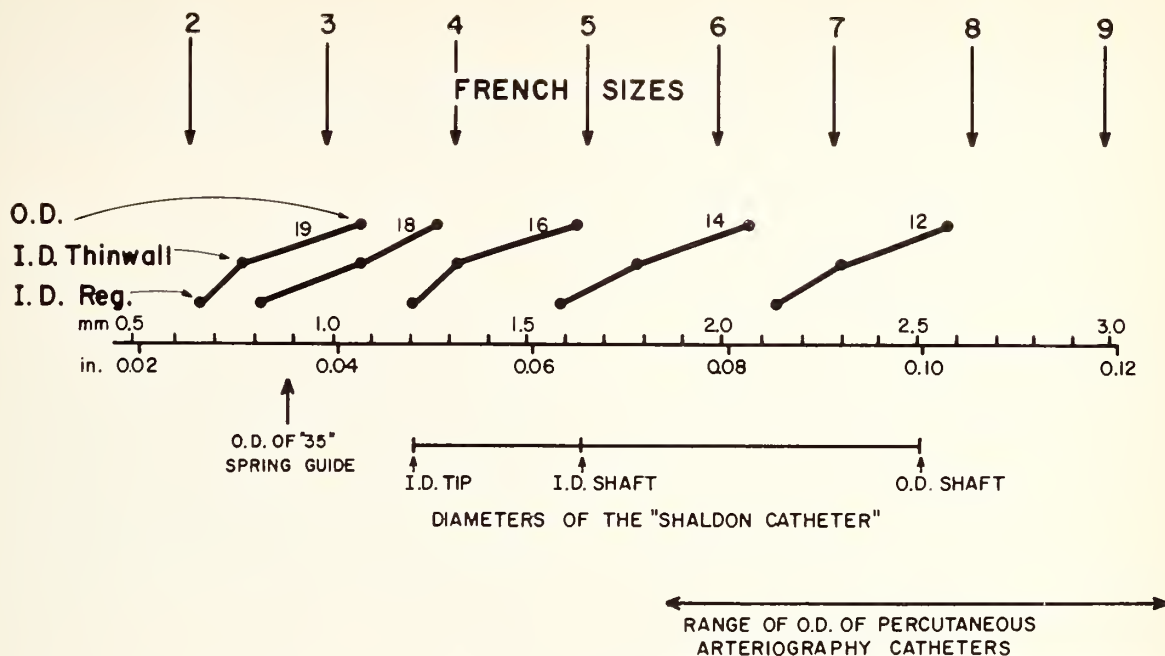


FIG. 2. This chart correlates different units of diameter measurement and on the same scale illustrates diameters of certain familiar needles and catheters. The long horizontal abscissa in the middle correlates millimeters with inches. The corresponding "French" sizes 2-9 are indicated at the top. Diameters of needles of 12, 14, 16, 18 and 19 gauge respectively are shown: "O. D." is the outside diameter of the needle; "I. D. Thinwall" is the inside diameter of a needle of the same gauge manufactured with a thin wall; "I. D. Reg." is the inside diameter of the needle manufactured of conventional proportions. For reference there are also indicated diameters of standard arteriography catheters and key diameters of the Shaldon catheter.

"puncture needle" (Figure 3)^b is used to enter the femoral vein. The outer part of this is a 16 gauge cannula with a blunt taper at the tip. Within the cannula is a fitted needle with a sharp point, which in turn has within it a stylette the tip of which is carefully matched to the needle.

This assembled "puncture needle" is held at an angle of about 30° to the skin, and its tip is passed through the skin, aimed just medial to the pulse of the femoral artery. Once the needle tip has traversed the skin, the stylette is removed, and a 10 ml. syringe is attached to the needle. As the needle is advanced, suction is gently applied through the syringe, so that as soon as the needle tip enters the femoral vein, blood will appear in the syringe. The needle is then removed from the cannula; venous blood should then drip freely from the outer end of the cannula (Fig. 4). A spring guide wire^c is then threaded through the cannula (Fig. 5), and passed 5 to 12 inches up the common iliac vein and into the inferior vena cava. If any resistance is encountered, the guide wire should be withdrawn and the cannula repositioned slightly: the guide wire

should never be advanced against resistance. Following passage of the guide wire, the cannula is removed and immediately the Shaldon catheter is threaded over the outer end of the guide wire and passed through the skin, fascia, into the femoral vein (Fig. 6), and so on until the catheter tip is judged to be in the inferior vena cava. Then the guide wire is removed, and a sustaining infusion is attached to the catheter.

A major advantage of the Shaldon catheter is that its outside diameter is small, and usually "source" and "return" catheters may be introduced through the same femoral vein (Fig. 7) thereby avoiding the need for immobilizing both of the patient's lower extremities during the dialysis. The second catheter is introduced in a similar fashion, but one or more inches *below* the entry point of the first catheter. (If the second catheter is inserted through the vein at a point *higher* than the first, the puncture needle may damage the first catheter.) A photograph of two catheters in place is shown in Fig. 8.

To reduce contamination of "source" blood with "return" blood, it is recommended that the catheter tips be several inches apart from each other (Fig. 7), and blood be drawn from the lower catheter.

The Shaldon catheter technique has been used by

(b) PN 16 Ga. Thinwall, Cat. No. 9145, U. S. Catheter and Instrument Co., Glens Falls, N. Y. Cost \$12.50 each.

(c) Spring Guide 120 cm. long, Cat. No. 9235, U. S. Catheter and Instrument Co. Cost about \$4.00 each.

us* at Riverside Methodist Hospital for 34 hemodialyses between April 16, 1965 and February 20, 1967.** During that interval there were only two patients who required dialysis in whom this method was not feasible. In one, an anomaly of the femoral veins prevented placement of the catheters in this fashion, and it was necessary to resort to a cutdown. In the other patient, the presence of a third degree burn of the entire lower half of the body made inadvisable the introduction of catheters in this manner, and peritoneal dialysis was used instead.

Complications

Complications have been few and minor. In one patient with severe circulatory congestion, venous hypertension caused oozing of blood around the

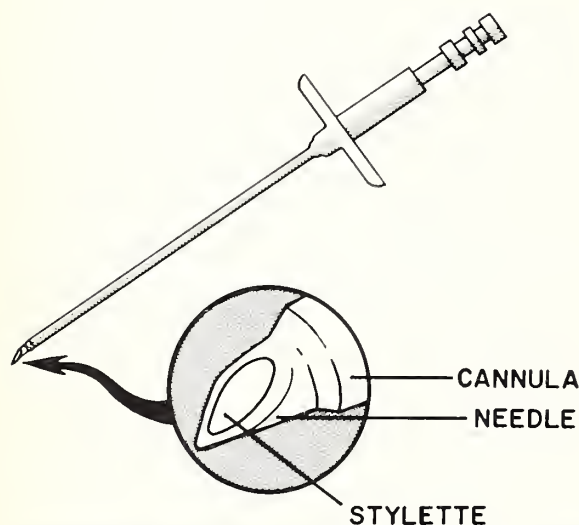


FIG. 3. Schematic of "puncture needle" described in text. The unit consists of an outer cannula, a sharply tapered needle inside the cannula, and a fitted obturator or stylette within the needle.

catheters causing a small hematoma to appear shortly after the catheters had been inserted. This was easily controlled by local pressure for 15 minutes and it was not necessary to remove or replace the catheters. In another patient, a hematoma formed under the skin during the sixth hour of hemodialysis; the reason for the occurrence of bleeding at this time is unknown. In another patient, an obese woman, it was not possible to pass the catheter through the right femoral vein, although the guide wire could be introduced a short distance. The left side was then used instead. This patient was somewhat over-heparinized during the dialysis, and during the fourth hour a hematoma was noticed in the right groin which finally amounted to about 500 ml. of

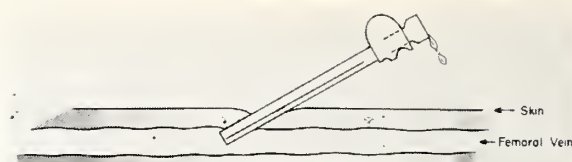


FIG. 4. Puncture cannula in place, tip within vein, with free blood flow from outer end.

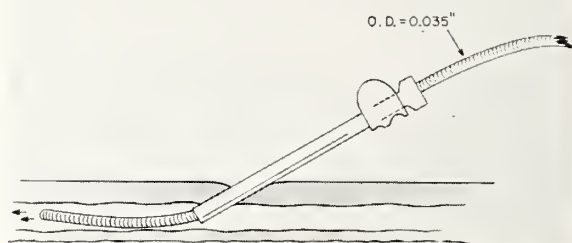


FIG. 5. Spring guide wire being passed through puncture cannula.

blood. This complication was treated by neutralization of the heparin with protamine, and firm pressure applied over the hematoma. This later reabsorbed without the need for incision and drainage. In two other patients, in whom insufficient heparin had been used, blood clotted within the catheters; they were easily replaced.

In three patients, the "source" catheter was passed into the femoral artery, because it was impractical to cannulate the vein in two places. (In Shaldon's early experience³ the "source" catheter was routinely placed in the femoral artery.) In these instances, firm manual compression was applied for 45 minutes after removal of the arterial catheter, and there was no difficulty with bleeding. We have had no instances of clinically identified phlebitis, probably because the catheters are left in place only for the duration of one dialysis.

When the dialysis has concluded, if the clotting time is not normal, protamine sulfate is given in a dose calculated to bring the clotting time to normal, and then both catheters are removed. Manual pressure is applied to the point of catheter entry for about 15 minutes, and then a 10 pound shot bag is left on the area for about six hours, following which the patient is allowed out of bed as desired. This promotes early full ambulation of the patient, in contrast to those restrictions imposed by the larger and unwieldy polyvinyl catheters^d which are left in place between dialyses. We have had no trouble with late bleeding or hematoma formation.

*On several occasions, the catheters were inserted by Dr. John F. Condon.

**To the date of correction of galley proofs, this technique has been used 38 times.

(d) Polyvinyl tapered catheters, Cat. No. U510, Travenol, Morton Grove, Illinois.

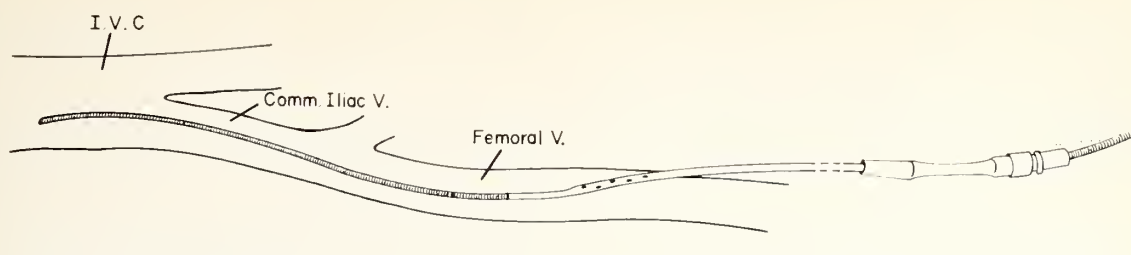


FIG. 6. Shaldon catheter being passed into vein over guide wire. The shaft of catheter is foreshortened in this schematic.

Efficiency of Dialysis

Shaldon's catheters are a little smaller in internal diameter than the standard polyvinyl disposable catheters (Fig. 2), and the blood flow through them, and consequently the dialyzer, at a given pressure, is a little less than with the bigger catheters. However, blood returning to the patient from any dialyzer, regardless of the blood flow rate or dialyzer efficiency, still has an abundance of urea, creatinine, and presumably the other "toxins" of uremia: thus the removal of these substances is not, as a practical matter, limited by the rate of blood flow through the dialyzer. With the Shaldon catheters, we are

able to get a blood flow of at least 200 ml. per minute with acceptable pressures in the blood lines. Careful analysis of the fall of the blood urea and creatinine concentrations and other changes during dialysis indicates that dialysis with these catheters is as efficient as with the larger catheters.

Advantages of Shaldon Catheter Technique

Both catheters may be inserted within about 20 minutes with a little experience on the part of the physician. This technique is obviously readily within the reach of any physician, and avoids the

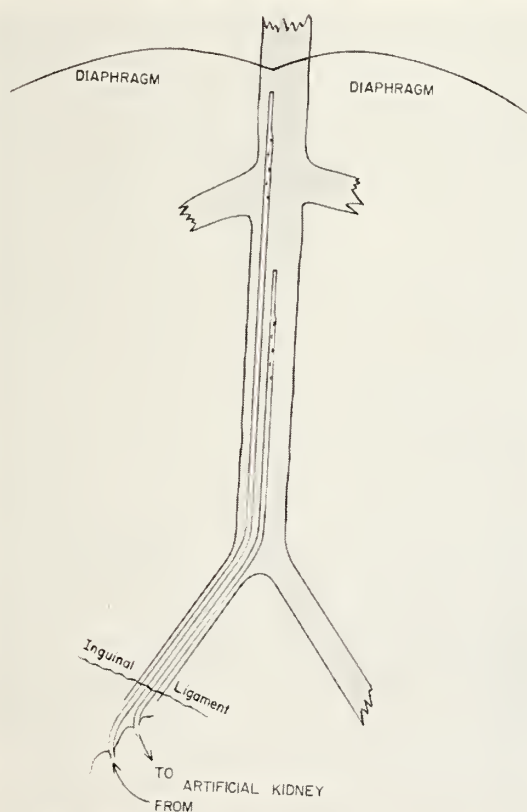


FIG. 7. Schematic representation of two Shaldon catheters lying with tips in inferior vena cava, having been passed through same femoral vein.



FIG. 8. Photograph of two Shaldon catheters in place, having been passed through right femoral vein. Blood lines from artificial kidney are attached to the catheters.

need for a surgeon. No cutdown, vessel ligation, or trip to the operating room is necessary, resulting in great economies of time, hospital and professional fees, as well as less trauma to precious veins. The ease of insertion and reinsertion of these catheters makes it convenient to remove the catheters between successive dialyses in the individual patient: this relieves the patient of the need for two sustaining infusions between dialyses, greatly facilitating am-

bulation and nursing care, and reducing the infection hazard.

There is a further advantage in that the Shaldon catheter is multi-eyed, in contrast to Travenol's polyvinyl catheter which has only a single opening at the tip. When the Shaldon catheter is used it is very rare, therefore, for the inflow of the "source" catheter to be obstructed; whereas with the use of the conventional polyvinyl catheter there is a constant need to monitor the inflow (negative) pressure, for the single opening of the latter tends to "seize" the vein wall and become obstructed thereby. This latter tendency is made worse by the fact that the polyvinyl catheters are packed "ready for use" in a *curl*, and the catheter tends to "remember" this curvature after placement in the vein. On the other hand, the Shaldon catheter may be autoclaved inside a glass tube which causes it to retain its straight shape.

Comment

This technique is ideal for the patient who needs hemodialysis only occasionally, or several times in a short interval. The femoral vein is large, and when

treated with reasonable respect, should serve for six or more pairs of catheterizations on each side.

Summary

The use of Shaldon's catheter inserted percutaneously into the femoral vein is a simple and almost universally applicable means of vascular access for hemodialysis. It is in many ways superior to the use of the conventional large polyvinyl catheters and is much easier than the installation of a Scribner-type shunt. This technique should be more widely employed than at present.

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SEA SHELLS AND SHOCK BOXES.— Shock boxes are being replaced by boxes of sea shells in the treatment of mentally ill veterans. In the process, more effective and humane care is provided and millions of dollars are saved each year. VA doctors are applying some old principles with new insight, and the payoff is help for mentally ill patients in half the time needed a few years ago.

A new approach to treatment puts the entire hospital staff on the treatment team. For each patient, the doctor prescribes one of five basic attitudes that should be adopted toward a patient by everyone concerned—doctors, nurses, attendants, and even maintenance men. A depressed patient, for example, might be treated with "kind firmness." Instead of using an electric shock to literally jolt a patient back to reality from a severely depressed state, doctors now insist, with kind firmness, that the patient work endlessly at a monotonous unrewarding task like sorting a box of sea shells. When the patient becomes so emotional about the monotony that he rebels, he is on the road to recovery, VA psychiatrists have learned. It works only if the attitude is applied consistently by all concerned. Still other patients might be treated with "active friendliness," "passive friendliness," "matter of factness," or "no demand."

Treatment programs of this type, coupled with the use of antipsychotic and antidepressant drugs, have wiped out the long waiting lists of veterans seeking treatment in VA psychiatric hospitals. At the Perry Point, Md. hospital, the waiting list often reached 350. Today there is no waiting list and the hospital has admitted 140 veterans formerly hospitalized in state and other institutions. A similar record has been set at the VA hospital at Tuscaloosa, Ala., where Dr. James C. Folsom developed the attitude therapy program.

The approach succeeds because everyone can understand attitudes—while psychiatric terminology may sound like mumbo jumbo to them and conventional treatment techniques seem vague and mysterious.—*Veterans Administration, Information Service, Washington, D. C.*, July 18, 1967.

Central Venous Pressure

The Rationale and Technique of Continuous Monitoring

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CONTINUOUSLY monitored central venous pressure has been in use for several years as a valuable adjunct to open cardiac surgery. The purpose of this communication is to advocate wider utilization of this technique in all types of major surgical procedures and to discuss some of the methods available to obtain accurate central venous pressure measurements.

One of the greatest aids to surgery in the twentieth century has been the widespread use of intravenous fluids as an integral part of successful therapy. These are administered, often in massive quantities, to place the patient in optimum condition for operation; to sustain him through what may be a prolonged and a shocking procedure; and to nourish him until he is capable of resuming normal alimentation after operation. Every surgeon has had the situation arise when he must ask himself if the patient needs more or less intravenous fluid. If the patient's condition is deteriorating, is it the fault of inadequate replacement or overtransfusion? Continuously monitored central venous pressure when used with the other parameters of urine output, blood and pulse pressure, and blood chemistries becomes a valuable and often essential guide for further therapy.

Central venous pressure is by definition that which exists in the great venous trunks of the body or their major tributaries without valves; or with physiologically incompetent valves. Many biologic forces contribute to the central venous pressure recorded at the bedside or the operating table. However, one may safely generalize by stating that central venous pressure is directly proportional to the rate of peripheral venous return and inversely proportional to the competence of the myocardium.¹ Additional modifying factors are intraabdominal, intrathoracic, and intrapericardial pressure.

Isolated measurement of central venous pressure is of little significance as normal values range from 0 to 100 mm. of water in the right atrium. This does not preclude the use of continuously monitored cen-

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tral venous pressure as changes in effective circulating blood volume or myocardial competence will be immediately reflected by a change in the central venous pressure.

Technique

To measure central venous pressure, one must have a catheter or needle in one of the great veins or its valveless tributaries. In clinical practice infusion of fluid is generally achieved via the same catheter used for central venous pressure measurement. Thus, a large bore catheter securely placed in a large vein is the ideal situation. This may be accomplished in several ways: in the lower extremity by cutdown on the saphenous vein in the groin with passage of a catheter into the inferior vena cava; or, by direct needle puncture of the femoral vein with passage of a catheter through the needle into the inferior vena cava. In the upper extremity a catheter may be passed into the superior vena caval system by cutdown on the external jugular vein in the neck, or median basilic vein at the elbow, or cephalic vein in the axilla. In addition, direct percutaneous puncture of the subclavian vein may be accomplished with passage of a catheter into the superior vena caval system.²

Catheterization of the superior vena caval system is the preferred route because of the ease of ambulating the patient and the relatively high incidence of complications following catheterization of the inferior vena caval system.³ Indications for catheterization of the inferior vena caval system are elective operations

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on the head and neck, intrathoracic procedures, and trauma to the neck and chest with possible injury to the superior vena cava or its major tributaries.

Once the catheter is in place it is connected to an ordinary venous pressure manometer with a three way stopcock at its base. Fluid to be infused is run in through the stopcock and into the central venous pressure catheter. The zero point of the manometer is placed at the level of the right atrium (Fig. 1). This is best approximated by placing a mark on the patient's chest midway along the anterior posterior diameter of the chest at the level of the fourth costochondral junction. Recently an ingenious method has been described using a flashlight attached by a sliding bracket to a centimeter scale.⁴ By focusing

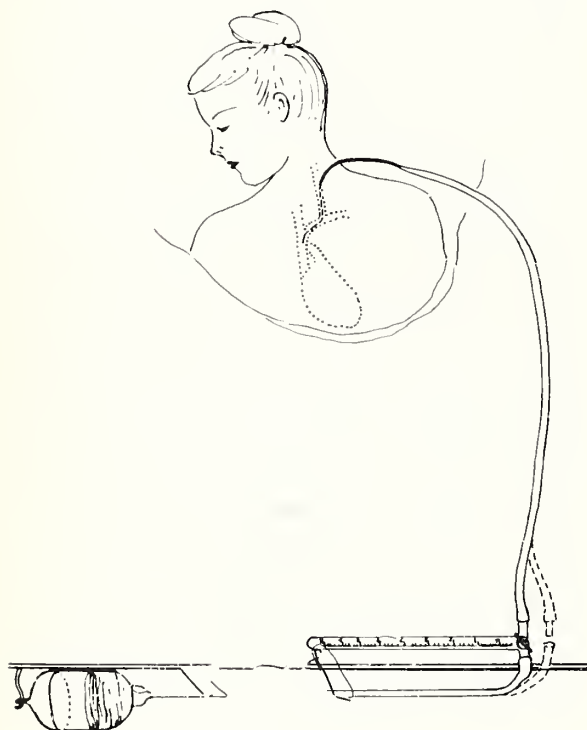


FIG. 1. Diagram of monitored central venous pressure via external jugular vein cutdown. The base of the manometer is set at the level of the right atrium. Note that the tubing may be easily disconnected from the manometer during periods of ambulation.

the flashlight on the marked area of the patient's chest an accurate reference point is always obtained.

Once the system is in place the central venous pressure may be instantly obtained by a turn of the three way stopcock. If the fluid level fluctuates freely with respiration one may be certain that an accurate measurement is being observed. Patency of the system is maintained by the continuous infusion of fluid via the catheter. Addition of small amounts of aqueous heparin to each bottle of intravenous fluid will often prevent thrombus from forming on the catheter tip.

Complications do occur. Longerbeam and co-workers summarized the complications reported by

eight authors who had indwelling catheters within the caval system or its major branches.¹ Over 1800 cases were reported with an average incidence of 4.5 per cent complications for catheterization of the superior vena caval system and 46 per cent complications for catheterization of the inferior vena caval system. Complications encountered included the following: pneumothorax, hemothorax, hydrothorax, subclavian artery puncture, thrombosis, thrombophlebitis, septicemia, pulmonary embolus, catheter embolus, air embolus, hematoma, and brachial plexus injury. There were two deaths.

However, it is of interest to note that one of the authors quoted utilized only the external jugular vein and in a series of 250 cases had zero complications.⁵ This is our preferred method and a brief discussion of its technique will follow.

The patient is placed in slight Trendelenburg position until the external jugular veins become prominent. In a small percentage of patients the external jugular veins can neither be seen nor palpated and experience has shown us that blind cutdown is unrewarding. It is better to select another site for cutdown or percutaneous puncture.

The patient's head is then turned away from the operator and the operative site prepared and draped in the customary manner. One per cent Xylocaine® with Adrenalin® is then infiltrated into the skin and subcutaneous tissue over the superior portion of the vein. A transverse incision is made through the skin and platysma muscle until the vein is encountered. The vein is then freed up and cleaned of adventitia. Care must be employed as it is fragile and easily torn. Encircling ligatures of 0000 silk are placed superiorly and inferiorly and a small venotomy is performed. The superior ligature is tied and left long for traction. A No. 8 French sterile pediatric feeding tube is passed into the venotomy and with a slight rotary motion may be passed into the subclavian and innominate veins and thence into the superior vena cava. The feeding tube is advisable because it is softer and more pliable than the ordinary venous catheter. In addition it is large enough for the rapid infusion of viscous fluids such as blood or plasma.

After passage of the catheter the inferior ligature is tied around the vein and then around the catheter to hold it in place. The ligatures about the vein are then cut close to the knot. The skin is closed with one or two sutures of 000 nylon which are tied about the catheter to prevent displacement. One or two Band-Aids are placed over the cutdown and complete the dressing. If unsuccessful in passing the catheter into the larger vessels it is still possible in most cases to measure central venous pressure with the catheter in the external jugular vein, as any valves present are usually incompetent.⁶

Once in place the catheter is well tolerated and the patient may ambulate and have full use of his hands without difficulty. The catheter may remain

in place for as long as a week without fear of complications. While not advisable, the junior author has noted several instances where external jugular catheters were in place for as long as two weeks with no untoward results.

To remove the catheter one has only to cut the skin suture holding the catheter in place and pull it out. There is generally no bleeding or at most slight oozing, which is easily controlled with pressure. The neck scar is usually quite inconspicuous.

Clinical Application

Our indications for monitored central venous pressure, particularly via the external jugular vein are liberal. These include any patient over 65 years of age undergoing a major operative procedure. Any patient with known pre-existing cardiac, pulmonary, or renal disease. Any patient requiring an operation of great magnitude such as pelvic exenteration; and any patient in whom prolonged or massive fluid therapy is anticipated such as a major burn, perforated peptic ulcer, or intestinal obstruction.

In our experience most patients have a normal central venous pressure of 3 to 8 centimeters of water. A filled vascular space may be assumed in most patients if the central venous pressure lies between 8 and 15 centimeters of water.⁷ Above 15 centimeters water pressure one must assume overtransfusion and/or cardiac failure.

The usual clinical situation encountered is a patient who is hypotensive and/or oliguric despite what seems to be adequate fluid replacement. If the central venous pressure is less than 15 centimeters of water, the first step is rapid infusion of suitable intravenous fluid. Large amounts of fluid may be infused with impunity, even to elderly patients with heart disease, as long as the central venous pressure does not rise above 15 centimeters of water.

A central venous pressure greater than 20 centimeters of water or a rapid rise of 10 to 12 centimeters after infusion of 250-500 cc. of fluid, indicates actual or functional hypervolemia.¹ If cardiac failure is present the true blood volume may be lower than normal, but the important fact is that further infusion of fluid will only create an increased work load on an already failing heart. In such a situation, accurate therapy can be begun immediately and its success or failure can be monitored by observing the central venous pressure.

A useful axiom in determination of therapy for the patient in shock is to transfuse with appropriate fluid until either the central venous pressure or the arterial blood pressure rises. If the blood pressure returns to normal levels first, a volume deficit probably existed. If central venous pressure rises prior to the arterial blood pressure, it is likely that a cardiac deficit predominates.⁷

In conclusion, we feel that continuously monitored central venous pressure is a modality of modern sur-



FIG. 2. A 64-year-old patient on her fourth day after resection of distal transverse colon, descending and sigmoid colon for extensive diverticulitis. Patient was formerly a narcotic addict and had few patent peripheral veins. Note small dressing required and complete freedom of both hands.

gical therapy which should receive frequent utilization. Techniques are available for safe cannulation of the great venous trunks for relatively long periods of time. In major illness or extensive operations, changes in central venous pressure provide the physician with the most accurate guide now available to monitor intravenous fluid therapy. Consequently, patient care is simplified and increased patient salvage may be anticipated (Fig. 2).

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Epidemic Histoplasmosis in Ohio With Source in Kentucky

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INTRODUCTION

EPIDEMIC histoplasmosis has been reported frequently in recent years. Most reports involve large groups of children or adults in contact with a point source of infection in an urban setting.¹⁻³ Less frequently an epidemic of one, two, or three cases is reported probably because the diagnosis is less obvious.⁴ The very small epidemic attracts less attention and may not suggest histoplasmosis. The patient may not relate that others have a similar illness unless the physician inquires. Epidemics involving large groups of people become known to physicians and the general public and are likely to be investigated and defined by a well equipped public health organization.

Acute pulmonary histoplasmosis may be mistaken easily for influenza, pneumonia, tuberculosis, or other respiratory infections and particularly in the small epidemic. When histoplasmosis is suspected, occupational contacts with chicken houses, bird roosts, cellars, caves, etc. should be investigated and the tools for investigation and diagnosis should be available to the physician. Fortunately the prognosis is good in this form and most patients recover without a diagnosis being made.

This is a story of a small epidemic of acute pulmonary histoplasmosis involving two brothers living in Ohio, one at Loudonville and the other at Creston. They went on vacation to visit their prior rural residence in Adair County, Kentucky from March 17 to 24, 1965.

While in Kentucky, they did carpentering for a sister. This involved spading up the dirt floor in an old chicken house and replacing it with a wooden floor. The older brother started the job of shoveling the dirt out the window. However, the younger brother and a nephew soon took over. The elder stood by and observed while the job was being completed. Approximately four days after the work began he became ill with an acute respiratory infection. Less than a week later the brother had the onset of a similar illness. The nephew who helped with most of the work did not become ill.

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The chicken house was the old variety with roosts and a dirt floor. It had been in continuous use for years; however, recently the number of chickens using it had decreased.

Case Reports

Case 1. O.J.V., a 60 year old white male native of Kentucky has lived in Ohio 40 years. He was first seen by his private physician who referred him to the Outpatient Department of Richland Hospital. He had onset of illness March 20, 1965, with chills, fever, and malaise. This was associated with an acute respiratory infection, cough, and expectoration. He spent two days in bed in Kentucky with some remission of symptoms and then returned home. The fever exacerbated and reached 103 F. He lost weight from 142 to 128 pounds. His previous history reveals he has had yearly chest x-rays which have been normal.

The general physical examination was not contributory to a diagnosis. The chest x-ray of April 22, 1965, showed increased hilar densities with an infiltrative and inflammatory process gradually fading out toward the periphery of both lungs (Fig. 1). This film when compared with the previous films of April 6th and 13th, made in Kettering Memorial Hospital, Loudonville, showed that a small amount of clearing in both lungs had already taken place.

The histoplasmin skin test showed 5mm induration and the intermediate PPD was negative. Two sputum smears and cultures were negative for acid-fast bacilli. A culture for common pathogens showed pneumococci, staphylococci, and *Neisseria catarrhalis*. Four specimens of sputum were collected by heated aerosol of isotonic saline solution and one was positive on culture for *Histoplasma capsulatum*. A sample of soil from the chicken house was overgrown on culture in our laboratory but the U. S. Public Health Service Laboratory at Kansas City reported *H. capsulatum* May 18, 1965.

The patient stated on clinic visit of May 26, 1965, that symptomatically he had made a complete recovery. Serial chest x-rays since December 15, 1965, have shown complete clearing of the process with no evidence of residual disease.

Complement fixation tests for histoplasmosis were highly positive. The results of these tests are given in Table 1.

Submitted April 10, 1967.

TABLE 1. Results of Complement Fixation Tests for Histoplasmosis, Case 1

Date	Laboratory	Histoplasmin	Yeast	Blastomycin
5/3/65	USPHS	1:128	1:128	1:8
6/9/65	USPHS	1:128	1:128	1:16
9/24/65	USPHS	1:256	1:128	1:16
12/20/65	Ohio State	1:256	1:128	
12/12/66	Ohio State	1:64	1:128	

Case 2. B. P. V., a 50 year old white male native of Kentucky, who has lived in Ohio 30 years, had onset of illness March 25, 1965, with cough, weakness, malaise, general aching and 15 pounds weight loss. He was admitted to Wadsworth-Rittman Hospital April 17, 1965. The past history was essentially negative except for bilateral pneumonia at age 11. He has had regular yearly chest x-rays at Wayne County Health Department.

Physical examination was essentially normal except for occasional moist inspiratory rales. Temperature was 99.6 F, pulse rate 84 per minute, respiratory rate 20 per minute, and blood pressure 110/70. Urinalysis, complete blood count, and fasting blood sugar with glucose tolerance tests were within normal limits. Serum glutamic oxalopyruvic transaminase was 124 and blood urea nitrogen 10.7. The electrocardiogram was normal. Gallbladder visualization showed some stones. X-ray surveys of the gastrointestinal and genitourinary tracts were normal. The histoplasmin skin test showed 3½ mm induration, and the blastomycin and coccidioidin skin tests were negative. The intermediate PPD skin test was positive. Sputum cultures showed essentially the normal pathogens. Two sputums were negative on smear and culture for acid-fast bacilli. Sputum collected May 13, 1965, by heated aerosol of isotonic saline solution was negative on culture for *H. capsulatum*.

Complement fixations for histoplasmosis were positive and are reported in Table 2.

Chest x-ray of April 19, 1965, showed a bilateral infiltrative and inflammatory process of moderate extent in both upper lung fields and of minimal extent in both lower lung fields (Fig. 2). Repeat chest x-ray of April 26, 1965, showed no essential change, however, film of January 5, 1966, showed considerable clearing in both lungs. There were some bullous emphysematous areas in the peripheral portion of the right upper lung and the apex. The last film of December 7, 1966, showed a small amount of residual infiltration in both upper lung fields.

Films of January 25, 1954, August 23, 1961, and October 20, 1962, from Wayne County Health Department showed scattered calcific densities in the left hilum downward to the sixth rib anteriorly and in the right hilum and the proximal half of the right midlung and a conglomerate calcific density in the right cardiophrenic angle. These calcific densities were irregular in size and shape. Subsequent film of November 9, 1963, showed an infiltrative process in the upper half of the right lung which in films of January 18, 1964, and July 28, 1964, consistently cleared leaving a small amount of residual fibrosis in the first interspace. The film of April 19, 1965, made after exposure to airborne infection in the chicken house showed a soft infiltrative process moderately dense in the right upper lung and less so in the left upper and gradually fading out toward both bases.

Discussion

The older brother who had the longest exposure to airborne infection was the first to develop illness.

The next brother developed it a few days later, but his illness required hospitalization and was slower in resolving. The chest x-rays of the two showed different characteristics. In the elder, the greater densities were in the hili and gradually fading out to the periphery, characteristic of acute pulmon-



FIG. 1.—(Case 1). Bilateral hilar densities gradually fading out toward periphery of both lungs. Acute pulmonary histoplasmosis.

ary histoplasmosis; whereas in the younger, the greater densities were in the apical areas and gradually fading out in the bases suggesting reinfection type of pulmonary histoplasmosis or tuberculosis—and with considerable calcification in both lungs as evidence of some type of previous infection. The acute illness similar to his brother's without finding acid-fast bacilli in the sputum may be presumptive evidence that the recent lesion is an acute pulmonary histoplasmosis. It is felt that if the previous lesion was

TABLE 2. Results of Complement Fixation Tests for Histoplasmosis, Case 2

Date	Laboratory	Histoplasmin	Yeast	Blastomycin
5/25/65	Ohio State	1:32	1:28	
6/2/65	USPHS	1:8	1:64	1:32
1/5/66	Ohio State	1:8	1:64	
12/15/66	Ohio State	nonreactive	1:32	

due to reinfection histoplasmosis, the present exposure may have caused an exaggerated allergic response in the upper lobe lesions producing acute pulmonary histoplasmosis simulating a reinfection pattern of disease.

There is no positive mycological evidence that the lesion seen in 1963-64 was histoplasmosis nor bacteriological evidence that it was tuberculosis since three sputum smears and cultures were negative for acid-fast bacilli by Ohio State Department of Health Laboratory. It is not known whether a previous reinfection type histoplasmosis would alter the response to a second airborne infection and produce the radiologic picture shown in Figure 2. It is felt that the type of distribution would depend more on

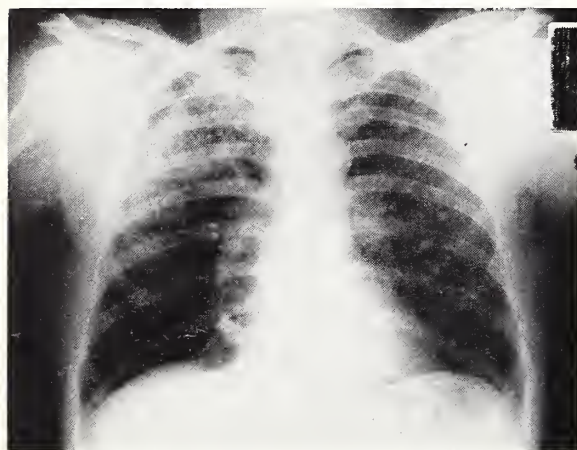


FIG. 2.—(Case 2). Bilateral infiltrative process in upper lung fields with more on right and gradually fading into bases. Acute pulmonary histoplasmosis simulating reinfection histoplasmosis.

whether it is an exogenous primary or an endogenous reinfection and it does not seem an unreasonable presumption that acute pulmonary histoplasmosis, superimposed on reinfection type histoplasmosis would simulate reinfection type of disease.

It is interesting to speculate why the nephew did not develop acute disease. He may have received frequent small doses of infection which developed his immunity. On the other hand, he may have had more innate immunity. The uncles had been away from Kentucky 40 and 30 years respectively and may have lost some of theirs. In the case reported by Murdock et al⁴ the man who purchased the bags of soil from a cemetery developed acute histoplasmosis, whereas, they did not report disease in the man who dug up the topsoil. Of course, at the time of digging, the conditions may not have been favorable for producing airborne infection.

Furcolow showed a relationship of increased sensitivity to histoplasmosis to increased time of farm visits by children.⁵ Intimate exposure to a point source of infection would be more dangerous. Those

who spend vacations on farms, in forested areas, and in exploring caves should be forewarned in regard to the dangers of exposure. In endemic areas health departments should mark known point sources of infection. Although this may not pose as much danger as polluted water the marking would serve to educate the public. This would not be necessary should the methods of decontaminating the soil prove successful as reported by Tosh et al.⁶

The findings of positive skin reactions, positive complement fixations, and the presence of calcium deposits in chest x-rays demonstrate that histoplasmosis is abundantly prevalent in a dormant form. Active disease is less frequently seen and therefore must be overlooked. In order to find the disease in its earlier stages, an awareness of its many manifestations has to be developed as well as a skill in the use of tests and laboratory procedures available for making the diagnosis. Some procedures, especially sputum cultures have to be done repeatedly to gain successful experience in this field. In general, State Health Department, U. S. Public Health Service, and Medical Center Laboratories are prepared to do satisfactory cultures for *H. capsulatum*. Many tuberculosis hospital laboratories are competent in this field. The competence of many general hospital laboratories should be improved. Definite diagnosis will not be greatly increased until more laboratories are qualified for doing serologies, cultures, and tissue examinations and the physicians made aware of where the tools for investigation and diagnosis may be obtained.

The source of the cases reported here was in one state and the epidemic outbreak in another. Year by year, there is an increasing number of people who spend vacations on farms, in exploring caves, and in camping outdoors including forests and wilderness areas. Thousands of Boy Scouts do this yearly. These people may engage in activities which would stir the spores into the atmosphere and bring them in contact with sources of infection. The epidemic reported here is an example and is more prevalent than assumed. For this reason, physicians should be aware of the possibility of histoplasmosis in respiratory illnesses that develop shortly following vacations spent in endemic areas. The potential sources of infection for epidemics of this nature have been recognized, but fewer of the small epidemics are reported.

Conclusion

This is a report of epidemic histoplasmosis in two vacationers with the source in a chicken house in another state. The diagnosis was established by skin tests, complement fixations, positive mycology in one patient, and from the floor of the chicken house. With increasing numbers of people spending their vacations on farms and other endemic areas of infection, physicians should be aware of the possibility of histoplasmosis in those who develop illness before

or after return. The facilities for diagnosis of histoplasmosis should be made known to physicians by health departments. The competence of general hospital laboratories in this field as well as other hospital laboratories should be improved. The known sources of infection in endemic areas should carry a warning label until satisfactory decontamination methods are developed.

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AN ESSENTIAL QUALITY. — The unique function and skill of a doctor is the ability to identify and evaluate the signs and symptoms of mental and physical disorder in a patient. It is a technical skill which must be learned in the undergraduate period, otherwise it is unlikely to be learned at all. It is founded upon a substantial body of knowledge, but it can be properly understood only by studying patients.

Diagnosis can no longer be taught as a matter of recognition, but as a precise assessment of clinical phenomena as evidence of disordered function. Problems must be studied in depth and much use made of laboratory methods of investigation which often demand an understanding of fairly complicated technical methods. Many have criticized this teaching as being too scientific, and have feared that the whole man will be lost in the analysis of the patient. Others have objected to what they regard as a specialist-based education with too much use of laboratory methods, and to undergraduate education being based upon observations drawn from rare and advanced cases which are believed to constitute the majority of those in teaching hospitals. Suggestions have been made that non-teaching district and regional hospitals would provide a better experience for students and future practitioners.

I do not share these views and believe that the best specialists are generally able to see their subject in relation to medicine as a whole. But with the rapidly changing technical processes of medicine the specialist sets standards to-day which will become general tomorrow. The general practitioner, whom some prefer as a model for students, and for that matter the general physician, will exist as reputable professional figures only in so far as they can master their essentials. Medical students cannot be streamed in the early stages of their career, and must be taught by the highest available standards to ensure that every practising doctor shall be thoroughly trained in sound clinical method. Even in the interests of producing more doctors quickly it would be wrong to set two standards in training deliberately. — Alastair Hunter, M. D., F.R.C.P., London, England: *British Medical Journal*, 2:552-557, September 4, 1965.

Eosinophilia Associated With Metastatic Carcinoma

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FIRST REPORTED more than 70 years ago by Rheinbach¹ the association of increased numbers of blood eosinophils with metastatic carcinoma is not generally known. It receives little attention in standard hematology textbooks^{2,3} and the majority of articles written on the subject have appeared in foreign language journals.⁴⁻⁹ In 1945, Isaacson and Rapaport¹⁰ reported 15 cases but since then only a few isolated cases have been reported.¹¹⁻¹³ The eosinophilia occurred with a wide variety of both epithelial and connective tissue tumors.

During the past five years we have observed three cases of metastatic carcinoma associated with an eosinophilia of more than 35 per cent. Because many clinicians seem to be unfamiliar with this association, which may represent a clue to the diagnosis of dissemination of neoplastic disease, we wish briefly to report these cases and to review some of the current concepts regarding the causes of eosinophilia.

Case Reports

Case 1. A 70-year-old woman was hospitalized with anorexia, pallor, and weight loss. Her symptoms began insidiously about three months before admission, and by the time of admission she had lost approximately 40 pounds. She denied previous illnesses and a routine blood count performed two years earlier was normal.

Physical examination revealed a pale, cachectic woman whose vital signs were normal. Coarse, moist rales were heard at both lung bases and there was a grade 2/6 harsh aortic systolic murmur. The abdomen was soft. A firm liver edge was felt about 4 cm. below the right costal margin and ill-defined, irregular, tender mass, about 6 cm. in diameter, was palpated in the epigastrium. The remainder of the examination was unremarkable except for marked muscle wasting in the limbs.

The hemoglobin was 6.8 Gm., the hematocrit 20 per cent, the white blood cell count 11,800 with 45 per cent neutrophils, 36 per cent eosinophils and 19 per cent lymphocytes. The urine analysis, blood urea, blood sugar, serum electrolytes and bilirubin were normal. Serum albumin was 3.1 Gm., globulin 3.2 Gm., alkaline phosphatase 7 Bodansky units, and bromsulfalein retention 14 per cent in 45 minutes. Two stools were negative for ova and parasites but positive for occult blood. The total eosinophil count was 3,600 per cu. mm.

The chest film demonstrated two 1 cm. round lesions in the right lower lobe, and a 2 cm. nodule in the left midlung field, all believed to be metastatic tumor. An upper gastrointestinal series showed a large, irregular tumor mass in the lesser curvature. Bone marrow examination showed

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normoblastic proliferation with normal white cell maturation. The eosinophils were increased in number. A twenty-four hour urine sample contained normal amounts of both 17-ketosteroids and 17-hydroxysteroids.

Her course was one of progressive deterioration, and she died twenty days after admission. Autopsy revealed adenocarcinoma of the stomach with metastases to the regional lymph nodes, the liver, and the lungs. The adrenal glands were free of tumor.

Case 2. A 52-year-old man was hospitalized because of postprandial pain which radiated into the lower chest. He had been hospitalized several times previously for symptoms (eg. pain, vomiting, etc.) related to his duodenal ulcer. One week prior to admission he had one episode of blood-streaked sputum but he denied any symptoms referable to the chest. A transurethral resection had been performed seven years before for prostatic hyperplasia. His hospital records indicated normal blood counts during each of his previous admissions.

The physical examination was unremarkable except for epigastric tenderness. His vital signs were normal.

The hemoglobin was 14.6 Gm., hematocrit 44 per cent, and white blood cell count 28,175 with 42 per cent neutrophils, 43 per cent eosinophils, and 14 per cent lymphocytes. The platelet count was 154,700. The urine specific gravity was 1.021, and the specimen contained many white and epithelial cells. The blood urea, blood sugar, serum electrolytes, calcium, alkaline phosphatase, transaminase, proteins, and bromsulfalein retention were normal. The chest film demonstrated a large hilar mass "consistent with carcinoma." An upper gastrointestinal series demonstrated a duodenal ulcer.

A repeat white blood cell count was 48,000 with essentially the same differential. The total eosinophil count was 11,488 per cu. mm. A bone marrow examination showed myeloid hyperplasia with normal maturation. Many mature eosinophils were present, but no tumor cells were noted. Three stool examinations were negative for occult blood, ova, and parasites. Bronchoscopy revealed a soft, friable mass in the right mainstem bronchus. A biopsy specimen taken from the mass was interpreted as a grade IV squamous cell carcinoma.

Three weeks after admission, the patient suddenly developed spastic paraplegia and sensory loss involving the legs and trunk below the seventh thoracic segment. Lumbar

puncture produced clear fluid with an opening pressure of 220 mm. The protein content was 186 mg. per 100 ml. and the cell count zero. Myelography revealed a total obstruction at the level of the seventh thoracic vertebra by a tumor mass. A decompression procedure was performed, but postoperatively the patient's clinical course was one of rapid deterioration and he died on the 28th hospital day.

Case 3. A 56-year-old man was hospitalized with a right hemiparesis. One month before admission progressive weakness of the right leg was noted. Two weeks before admission, he noted the onset of weakness in the right arm. At the time of hospitalization, complete paralysis of the leg had occurred. He had lost 20 lbs. during the previous month, and the family had noted that his personality which previously had been very jovial, became subdued. He denied any chest symptoms, and a chest x-ray, obtained one month before admission, was reported as normal. No previous blood abnormalities were known by the family physician.

Physical examination revealed spastic paralysis of the right leg and marked weakness of the right arm with hyperactive deep tendon reflexes. The cranial nerves were intact except for minimal weakness of the muscles innervated by the right facial nerve. There was no sensory loss. Funduscopic examination showed bilateral papilledema (4 diopeters). The remainder of the physical examination was unremarkable, and the vital signs were normal.

The hemoglobin was 15 Gm., hematocrit 52 per cent, white blood cell count 23,700 with 51 per cent neutrophils, 37 per cent eosinophils, 9 per cent lymphocytes, and 3 per cent monocytes. The urine analysis, blood urea, blood sugar, serum electrolytes, acid phosphatase, alkaline phosphatase, serum protein electrophoresis, and bromsulphalein retention were normal. Three stool examinations were negative for occult blood, ova, and parasites. Bone marrow aspiration showed normal white cell maturation with an increase in eosinophils. No tumor cells were seen. Lumbar puncture produced clear fluid with an opening pressure of 235 mm. The fluid contained 30 mg. of protein and 3 lymphocytes.

The chest x-ray demonstrated enlarged hilar nodes bilaterally with a round, 1 cm. homogenous density in the lower left lobe. Skull films, gastrointestinal x-rays, and pyelography revealed no abnormalities.

Repeat blood counts continued to show a marked eosinophilia (40-45 per cent) and the total eosinophil count was 8,800 per cu.mm. An electroencephalogram showed non-specific changes without localization. Pneumoencephalograms demonstrated a mass lesion in the left posterior parietal area with flattening of the left lateral ventricle. A left scalene node biopsy revealed metastatic epidermoid carcinoma, grade II.

In view of the lesions noted on the chest film, the positive node biopsy, and the inability to discover a primary lesion elsewhere, it was believed that the patient had carcinoma of the lung with cerebral metastases. Treatment of any type was refused by the family. The patient was discharged and he died at home three months later.

Discussion

In these cases, other conditions associated with eosinophilia (including leukemia, polyarteritis, Hodgkin's disease, parasitic infestation, allergic reactions, Löffler's syndrome, radiotherapy, splenectomy, adrenocortical insufficiency, and recovering from a febrile illness) were excluded on the basis of the laboratory and clinical findings.^{2, 3} So-called "familial" eosinophilia is now believed to be due to visceral larva migrans, the helminths infecting several members of the family.¹⁴ Rarely a marked eosinophilia may develop without an obvious cause and subside spontaneously.¹⁵

Relatively little has been known about the eosinophil, and several theories were proposed to explain

how tumors might induce eosinophilia. Some early investigators^{4, 5} believed that tumor necrosis released eosinophilotactic substance, and an increase in the absolute eosinophil count has been suggested as a means of differentiating a necrotizing tumor from a simple infectious process.¹⁶ Although the surgical removal of the primary tumor caused a reduction in the eosinophil count in several instances,^{6-8, 12, 17} extracts of the tumor from one patient failed to evoke eosinophilia when injected into laboratory animals.¹⁷ Other authors⁹ suggested that blood eosinophilia resulted from an "overflow" of eosinophils from the connective tissue surrounding the neoplasm, but such a concept implies an extramedullary origin of eosinophils which has never been established. According to Isaacson and Rapaport¹⁰ some authors attributed the eosinophilia to bone marrow metastases with selective proliferation of the eosinophils, but such bone lesions have not been demonstrated.

More recent studies indicate that eosinophilia results from the interaction of immune complexes.^{18, 19} Although there is a correlation between antibody levels and eosinophil response²⁰ which is suppressed by corticosteroids,¹⁸ it appears that the eosinophilia results from the union of antibody and antigen rather than from the presence of antibodies alone.^{19, 21} However, at least one instance of eosinophilia has been reported in a patient with immune globulin deficiency.²² By immunofluorescent techniques Litt¹⁹ demonstrated phagocytosis of the antigen-antibody complexes by eosinophils. Most observers seem to agree that proteins and/or complex polysaccharides are the substances which provoke an eosinophilic response.

Although several substances can produce eosinophilia, it is believed that histamine is the humoral substance which stimulates the production of eosinophils by the bone marrow.¹⁸ Several investigators^{23, 24} have demonstrated antihistaminic activity by eosinophils and phagocytosis of mast cell granules which seem to be the main source of histamine in the body.^{25, 26} In view of these findings and the preferential location of eosinophils in the epithelial surfaces, it seems that the eosinophil has a protective function by neutralizing toxic and foreign protein-polysaccharide substances.

One might postulate that the eosinophilia occurring with tumors results from the production of some histaminelike substance by the neoplasm. However, the histamine content of tumors is reported to be low.²⁷ More likely sites of histamine production are the mast cells which commonly surround tumors. Since Paul Ehrlich first described the mast cell in 1878, numerous investigators have observed increased numbers of these cells around the neoplasm^{25, 26} and it has been suggested that mast cells inhibit its spread.²⁸⁻³⁰ Conceivably injury to the mast cells by the tumor results in the release of histamine producing the eosinophilia. The mechanism by which the

mast cell discharges its granules is believed to be the result of an antigen-antibody reaction.³¹ We attempted to evaluate the mast cell reaction in the histologic sections from Case 1 but the tissue specimens were initially fixed in plain formalin, which makes them unsuitable for staining mast cells.

In this paper we have pointed out the association of eosinophilia with metastatic carcinoma and briefly reviewed some of the current concepts regarding the eosinophil and its function. With continued research in this area, further understanding of the mechanism involved should soon be forthcoming.

Summary

Marked eosinophilia may develop with metastatic carcinoma. Three cases are reported, the primary tumor being gastric in one patient and pulmonary in two. Current research indicates that eosinophilia results from the interaction of the immune complexes, and histamine is believed to be the humoral substance which stimulates eosinophil production by the bone marrow. The mechanism by which tumors may cause eosinophilia is discussed.

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TREATMENT OF PULMONARY EMBOLISM. — Forty-five patients with pulmonary embolus were treated with fibrinolytic. Two had previous vena cava ligations and were treated to prevent exacerbation of the edema and thrombophlebitis.

Fourteen had massive embolism. Nine of these (64 per cent) survived the embolus. Five (36 per cent) died acutely from the embolus or irreversible changes despite apparent dissolution of the clot in three. Five others died of other disease after apparent recovery from the embolism.

Thirty patients were treated for acute single (not massive) or multiple pulmonary emboli. Of these, 25 survived. Of those who survived, two had recurrence of emboli and a vena cava ligation was successful. Two others had late (5 months and 18 months) recurrence of emboli with massive occlusion and death. — Eugene E. Clifton, M.D., New York: *Bulletin of the New York Academy of Medicine*, 43:267-281, April 1967.

Cancer of the Prostate

A Discussion of Guidelines in the Diagnosis

R. ROMAN, M. D.

AS A MAN ages, there is a dramatic increase in prostatic cancer. From relatively rare deaths among men under 40 years of age, it becomes the third highest cause of cancer deaths among men after age 55 and the principal cause of such death after age 75.¹

Although there are several procedures for detecting the early malignant lesions in a prostate, none is completely reliable. The most generally used methods of detection are:

1. **Rectal Digital Palpation of the Gland.** A nodule, induration, fixation, or asymmetry of the prostatic gland on palpation should be investigated for malignancy. Almost 50 per cent of such changes are found to be malignant on microscopic examination of the tissue, in which the roentgenogram failed to disclose a calculus. Benign nodules could be prostatic hyperplasia, prostatitis, calculi, tuberculosis, infarct, or granulomatous prostatitis. About 10 per cent of prostatic carcinomas do not give the sensation of induration to the examining finger. These cases include carcinoma which is soft, carcinoma in situ (very early stage) and a small carcinoma buried deep in other than the posterior lobe.²

2. **Serum Acid Phosphatase Levels.** The acid phosphatase of the prostate (also liver and spleen) is inhibited by L-tartrate where that of other tissue is not. Inasmuch as virtually no other tissue is capable of forming sufficient amounts of this enzyme to raise its concentration in the blood plasma to a high level, such increases may be regarded as presumptive, and at times conclusive evidence of the presence of prostatic cells outside the prostatic capsule, i.e., carcinomatous metastasis. Prostatic acid phosphatase (L-tartrate inhibited) should be ascertained in each total serum acid phosphatase determination.

3. **Cytologic Studies of Prostatic Fluid.** It should not be used as an isolated screening technique.

4. **Biopsy Procedures.** Whenever there is a question of the histological nature of any prostatic changes on rectal palpation, a biopsy should be made.

The Author

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Biopsies can be made transperineal or transrectal (most of the time with a needle), open perineal, retropubic and transurethral. All have their use in certain situations.

Early investigators were aware of the high incidence of this malignancy. In the year 1900 Albarran found 14 cancers in 100 hypertrophic prostates.³ Young says: "We may say that, roughly and for practical purposes, 20 per cent of all men over 60 will have symptoms due to prostatic trouble and that of these, 20 per cent will have cancer."⁴

At the present time we admit that about 20 per cent of men over 55 years of age have prostatic carcinoma.

The results of the accuracy of the different biopsy techniques vary from one author to another. There are about 10 per cent positive results in random, open perineal biopsies, making this technique 50 per cent accurate.⁵⁻⁷

With needle biopsy the accuracy of results also varies. It has been reported, that when used to obtain tissue from suspicious nodules, the accuracy of the results goes as high as 88 per cent.

The transurethral biopsy should be practiced only in conjunction with relief of obstructive changes. The majority of these tumors originate in the posterior portion of the prostate, making this procedure valuable only in advanced cases.

A negative needle biopsy has value only when the histological findings show why the prostate presents such changes (granulomatous prostatitis, etcetera).

The practice of administering estrogens as a therapeutic test, assuming that local softening, shrinkage

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or disappearance of the nodules rules out cancer, is to be condemned as dangerously inconclusive.

I have done 100 random percutaneous, perineal, needle, prostatic biopsies with the following findings:

Carcinoma	16
Benign Prostatic Hypertrophy	73
Old Infarct	1
Prostatitis	4
No gland obtained	6

In this series of needle biopsies, 16 were positive for carcinoma. Four cases reported to have benign conditions on the needle biopsies were positive for carcinoma in (two) enucleated prostate and in (two) cases in the tissues removed by transurethral resection (T.U.R.). Fifty-five were done at the time of prostatic transurethral resection, with four reported as carcinoma. In these last four cases, carcinoma was present in an unsuspected area, while the resected tissue was devoid of tumor.

All but two of the positive tissue biopsies for carcinoma of the prostate on T.U.R. had been previously diagnosed by needle biopsy, with suspicious rectal examination. One case that was not suspicious on rectal prostate palpation revealed carcinoma on the needle biopsy.

In 73 benign prostatic enlargement tissue reports, rectal examination was suspicious in 70 cases.

One case treated with estrogens, after a clinical diagnosis of carcinoma of the prostate 12 years prior, did not show cancer in two biopsies of the prostate and did not show carcinoma of the prostate in two separate T.U.R.'s. No evidence of metastases was found in the two hospitalizations.

Summary

1. We should be very cautious in making a diagnosis of prostatic carcinoma by clinical evidence alone.

2. Prostatic acid phosphatase has value in following response to therapy and as a guide to prognosis in selected cases.

3. All biopsy procedures have their merit in different situations, and are complementary rather than competitive.

4. Perineal open biopsy should be done, if the patient strictly fulfills the prerequisites of radical prostatectomy.

5. Histologic proof of carcinoma is mandatory for radical prostatectomy or for orchidectomy.

6. Transurethral or enucleation prostatectomy with no biopsy of the posterior true prostate will miss the diagnosis in a certain percentage of cases.

7. Prostatic cancer is within easy reach of the examining finger. The responsibility of the practitioner for the early detection of this disease is plainly evident.

It is most desirable in the diagnosis of prostatic carcinoma to sample the posterior portion of the true prostate each time suspicious changes occur in this area and routinely to do prostatic needle biopsies as part of prostatic surgery.

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DIAGNOSTIC PARACENTESIS, studied in 101 patients admitted as cases of acute abdominal emergency, has been shown to be both simple and safe. Though visceral puncture may occasionally occur, no complications have resulted.

Analysis of the results shows that a high yield (approximately 80 per cent) of positive paracenteses can be expected in cases of intraperitoneal hemorrhage and perforated viscus. Conversely, a very low yield (less than 10 per cent) was obtained in localized inflammatory disease. The test is strongly recommended as routine in all cases of blunt abdominal trauma. It is also extremely useful in the early diagnosis of complications after abdominal surgery. In visceral perforation the method offers a useful alternative to radiological diagnosis, and in certain respects is to be preferred.—W. N. W. Baker, M.B., B.S., F.R.C.S., et al., London, England: *British Medical Journal*, 3:146-149, July, 15, 1967.

Spatial Vectorcardiography

III. Automatic Recording

ROBERT T. MURNANE, M.D.*

Special Galvanometer

MANN (1938) reported the application of a unique galvanometer, capable of responding simultaneously to three electric currents and permitting direct recording of VCG loops. His records resembled those he had obtained earlier by graphic construction and those obtained later with the cathode-ray oscilloscope. His instrument, known as the Monocardiograph, was not widely adopted because of easier application of the simple cathode-ray oscilloscope to loop VCG.

The Cathode-Ray Oscilloscope

Schellong in Germany (1937) and Johnston in the United States (1938) demonstrated the advantages of the oscilloscope to display vectorially in loop form the temporal and spatial characteristics of cardiac electromotive force (EMF). Widespread acceptance of the technique was delayed in part because agreement was not reached regarding the lead system to be used and because of the limitations of available electronic recording equipment.

Coincident with advancements in instrumentation, several investigators independently proposed lead systems with variable practical and mathematical limitations. The newer corrected orthogonal lead systems include those of McFee-Johnston, Schmitt-Simonson, Burger-van Milaan, and E. Frank. Many laboratories have recently adopted the network proposed by Frank, whose system permits easy clinical application and gives results close to those obtained with more complex lead systems.

As commonly employed, the oscilloscope presents the loop pathways of atrial and ventricular electrical activity onto three mutually perpendicular planes. These include frontal, sagittal, and horizontal views of the atrial P loop and ventricular QRS and T loops.

Modern oscilloscopes used for vectorcardiography have facilities for interrupting the loop at regular

intervals to provide accurate timing. It is conventional to interrupt the beam at .002-sec. intervals. The direction of loop inscription can be determined by the use of comma-shaped dots. A trace-speed sensing device dims the slower writing portions of the trace to minimize fogging at the "E" point. The oscilloscope trace may be photographed by several methods, such as the Hart portable vectorcardiograph (Model PV-4) employing a Polaroid camera.

Recording oscillographic loop VCGs with the Frank system requires more meticulous attention to detail than does the ordinary clinical ECG. However, it can be taught to the technician and performed at the bedside.

Advantages

As indicated in the previous fascicle, the complexes of a technically excellent scalar ECG can be dissected into intervals as brief as .01-sec. duration. The oscillographic VCG can be analyzed at intervals as short as .002 sec.; thus, subtle form alterations can be seen that are frequently not evident in ordinary scalar ECGs, from which directions of loop inscription cannot reliably be predicted. Conduction delays and hypertrophy patterns can be more readily located and their significance more easily appreciated with the loop presentation. Of these advantages the most useful clinically has been the minor form alterations of the loop seen with small areas of myocardial destruction resulting from any of several etiologies.

Disadvantages

Among the foremost shortcomings of oscillographic loop VCG is its inability to provide information about rhythm disturbances and interval measurements between events of a single AV complex. Technically excellent records cannot always be obtained because of somatic tremor in the seriously ill patient.

Proficiency with graphic construction methods from the scalar ECG requires vector analysis of a minimum of 100 clinical records. Proficiency with

The Heart Page is a periodic feature of *The Journal* containing brief, practical comments on subjects of immediate importance to practicing physicians. The comments are solicited by the Professional Education Committee of the Ohio State Heart Association.—Ed.

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a system of oscilloscopic VCG can be acquired with one year of undivided attention to its clinical application.

These articles have essayed to provide some insights into elementary concepts of spatial VCG. They are based on the work of our predecessors who have

provided the groundwork and delineated the challenges for future vectorcardiographers.

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The Project in Oscilloscopic Spatial Vectorcardiography has been supported by grants from The Central Ohio Heart Association.

A CLASSIFICATION OF GENETIC DIABETES MELLITUS based on abnormalities of carbohydrate metabolism is given below. Progression or regression from one stage to the next may never occur, may proceed slowly over many years or may be very rapid. This classification does not consider the presence or absence of vascular disease, for patients with minimal glucose intolerance or even normal tolerance may have angiopathy.

1. *Overt Diabetes Mellitus*: This is frank diabetes, either of the ketosis-prone or ketosis-resistant type. Fasting hyperglycemia is present. Symptoms of hyperglycemia and glucosuria may be present. A glucose tolerance test is not required for diagnosis.

2. *Chemical or Latent Diabetes*: This is asymptomatic diabetes. The fasting blood glucose level may be elevated but is usually normal and the postprandial level is frequently elevated. Oral or intravenous glucose tolerance tests performed in the absence of "stress" give results in the ranges accepted for diabetes.

3. *Suspected Diabetes Mellitus* (Including "Stress" Hyperglycemia): Persons who have temporary carbohydrate intolerance in certain physiological or pathological situations should be suspected of having diabetes mellitus, particularly when there is a family history of diabetes. Symptoms due to severe hyperglycemia occurring during periods of "stress" should be regarded as representing overt diabetes until proved otherwise. Asymptomatic or symptomatic derangement of carbohydrate tolerance should be re-evaluated after total recovery from the "stress." In particular, impaired carbohydrate tolerance in the following situations requires long-term evaluation:

A. *Pregnancy*. The term "gestational diabetes" indicates the presence of abnormal glucose tolerance which reverts to normal following delivery. In these individuals follow-up studies have revealed a high risk of development of diabetes. (Diabetes should also be suspected in a woman whose obstetrical history includes large babies, unexplained abortions, fetal deaths, neonatal deaths, or hydramnios.)

B. *Obesity* with abnormal glucose tolerance which returns promptly to normal with moderate weight loss.

C. *Infections*, trauma, vascular accidents, burns, impaired nutrition, and severe emotional disturbances.

D. *Treatment* with pharmacologic agents, such as corticosteroids or thiazides.

E. *Endocrinopathies* such as acromegaly, Cushing's syndrome, thyrotoxicosis, and pheochromocytoma. (Diabetes must also be suspected in elderly subjects without symptoms and signs of the disease but with a glucose tolerance test which in younger individuals would be considered abnormal.)

4. *Prediabetes*: Prediabetes is a term applied to the period of time prior to the onset of identifiable diabetes mellitus (overt, chemical or latent). This is a conceptual term identifying the interval between fertilization of the ovum and the demonstration of impaired glucose tolerance in an individual predisposed to diabetes on genetic grounds but presently exhibiting a normal glucose tolerance. It cannot be diagnosed with certainty in the current state of our knowledge except in the nondiabetic identical twin of a diabetic patient and possibly in the offspring of two diabetic parents. — *American Diabetes Association, Inc.*, NEWS RELEASE, July 28, 1967.

A Clinicopathological Conference

From The Ohio State University Hospital, Columbus, Ohio

Edited Under the Auspices of the Ohio Society of Pathologists

PAUL N. JOLLY, M.D., *President*

PRESENTATION OF CASE

THIS 66-year-old white man was referred to University Hospital because of pain in his left hip and a persistently draining abscess in the left inguinal area. He had been in good health until five months prior to admission when anorexia, pain in his left hip and a "flu-like" syndrome developed. His local physician felt a mass in the patient's left lower abdominal quadrant. A barium enema showed a probable neoplasm in the descending colon and an exploratory laparotomy was performed. No pathologic change was found in the colon at surgery, but a large retroperitoneal inflammatory mass, apparently lymph nodes, was present near the descending colon. A biopsy of this mass revealed nonspecific chronic inflammation. On antibiotic therapy he did well for several weeks.

Four months prior to admission he noted severe pain in his left hip and x-rays revealed gas in the area of the left femur and hip joint. A left inguinal and femoral surgical exploration disclosed a large abscess in the left hip joint and large inflamed lymph nodes which again showed chronic nonspecific inflammation on biopsy. Tuberculosis was suspected and appropriate cultures were taken, the results of which are unknown. The patient was treated with drainage, Chloromycetin® and dihydrostreptomycin, both parenterally and locally. He did relatively well although the wound in his left inguinal area continued to drain. He was readmitted two months later and the wound was re-explored and treated with suction and irrigation for nine days.

One week prior to the admission to University Hospital the patient had an episode of cyanosis, diaphoresis, and apprehension. A chest x-ray and electrocardiogram were thought to be compatible with pulmonary embolism. He responded quickly to treatment with oxygen. During the last two hospitalizations the patient required 4 units of blood to maintain his hemoglobin in the range of 11 Gm. The only other significant history was that the patient had had a weight loss of 40 lbs. in

Presented by

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 - Emmerich von Haam, M.D., Columbus.
- Edited by Dr. von Haam.

the last five months. He had had no gastrointestinal symptoms. He was transferred to University Hospital for further treatment.

Physical Examination

On admission to University Hospital the patient appeared chronically ill but in no acute distress. His temperature was 102 F., blood pressure 140/80, pulse rate 100 per minute and regular, respiratory rate 14 per minute. The chest was clear to auscultation and percussion. The point of maximum impulse was 2 cm. lateral to the left midclavicular line in the fifth intercostal space. The heart sounds were normal. Liver and spleen were not enlarged. The abdomen was soft with active bowel sounds. There was left lower quadrant tenderness, and one observer felt an ill-defined mass in that area. The rectal examination revealed no abnormalities except that the stool was a trace guaiac positive. The left hip was tender to palpation and any motion of the leg produced pain in the hip. There was pitting edema of both lower extremities up to the sacrum. No abnormal nodes were palpated. Results of the neurologic examination on admission were normal.

Laboratory Examinations

The hemoglobin level on admission was 10 Gm./100 ml., hematocrit 34 per cent. With blood transfusions the hemoglobin was maintained within this range. The white blood cell count (WBC) on admission was 16,200, later dropping to 4,987. The differential count on admission showed 89 per cent polymorphonuclear leukocytes (PMN), 11 per cent lymphocytes. On various occasions up to 96 per cent of the leukocytes were PMNs. The blood urea

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nitrogen level on admission was 21 mg./100 ml.; it gradually rose to 52 mg. before death; the creatinine was 1.1 mg./100 ml. on admission, rising to 2.2 mg. at the time of death. The urine had a specific gravity of 1.024, a trace of protein, no sugar, and microscopic examination revealed a few coarsely granular casts, 20 WBCs and 1-2 RBCs, and a few bacteria per high-power field.

The serum sodium value was 134 mEq./liter, potassium 3.9 mEq., chlorides 99 mEq., and CO₂ combining power 26 mEq. The fasting blood sugar level was 91 mg./100 ml.; total protein 5.1 Gm./100 ml. (albumin 2.9 Gm., globulin 2.2 Gm.); calcium 4.4 mEq./liter; inorganic phosphorus 3.7 mg./100 ml.; alkaline phosphatase 4.4 K.B.R. units shortly after admission, peaking at 6.3 K.B.R. units; acid phosphatase 0.45 units; total bilirubin on admission 0.6 mg./100 ml. with direct reading of 0.1 mg., rising to 7.8 mg. total and 5.5 mg. direct at the time of death. The serum glutamic oxaloacetic transaminase (SGOT) was 12 units, the glutamic pyruvic transaminase (SGPT) 6 units, and the lactic dehydrogenase (LDH) 492 units. Results of serum protein electrophoresis were: total protein 5.1 Gm./100 ml.; albumin 35 per cent; alpha 1 globulin 9.8 per cent; alpha 2 globulin 13.4 per cent; beta globulin 13.6 per cent, and gamma globulin 27.2 per cent. The prothrombin time was 29 per cent of normal.

On admission the blood cultures were negative. Throat and sputum cultures grew normal flora. A light growth of a coliform and *Proteus mirabilis* was obtained from the abscess. *Pseudomonas* grew from the urine. Several sputum specimens and several specimens from the abscess were negative on smear for acid-fast bacilli and cultures subsequently showed no *Mycobacterium tuberculosis*. Purified protein derivative No. 2 (PPD) test was negative.

Review of the x-rays taken at the other hospital showed rapid destruction of the left hip over a three-month period, compatible with septic arthritis and a draining sinus. The chest films were interpreted as compatible with clearing of suspected pulmonary infarction. An intravenous pyelogram showed normally functioning kidneys. A chest film taken shortly after admission here showed an enlarged heart and increased pulmonary vascularity in the hilar regions. Barium enema showed an area of sigmoid diverticulosis and possible diverticulitis with considerable spasm.

The electrocardiograms showed premature atrial and ventricular contractions with T waves consistent with anterior ischemia.

Hospital Course

The patient was intermittently febrile throughout his hospital stay. On the second hospital day the abscess began draining bright red blood. Pressure dressings were applied and the bleeding stopped.

On the third hospital day the patient's temperature spiked to 104 F. and his blood pressure fell to 90/50. Treatment was started on cephalothin and colistin intramuscularly, and with Solu-Cortef® and intravenous fluids his condition stabilized. Blood cultures now grew gram-negative rods, identified as *Proteus mirabilis* and *Escherichiae*, in four out of six bottles. On the tenth hospital day the patient complained of weakness in his right arm and six hours later apparently had a brief respiratory arrest. On the 16th hospital day he was afebrile and antibiotics were discontinued. The inguinal abscess was probed and irrigated and a catheter was inserted. Injections through the catheter delineated an extensive psoas abscess cavity extending up to the L-4 interspace.

On the 22nd hospital day the patient suddenly began to bleed bright red blood from the abscess cavity. He was taken immediately to the operating room and the left superficial femoral artery was ligated. Several hours later the bleeding recurred and the patient became hypotensive. Ligation of the left common iliac artery and a transverse colostomy were then performed. After he was returned to his room he had a brief cardiac arrest but was resuscitated.

Postoperatively, the patient developed respiratory difficulty and a pleural effusion and probable pneumonitis were noted clinically and radiographically. He became less responsive and had fasciculations of his right leg, nystagmus with the slow component to the right, and his left side appeared flaccid. On the 30th hospital day (day of death) a lumbar puncture was performed. The spinal fluid was yellow and there were numerous organisms in the smear which were thought to be gram-negative rods. The spinal fluid had 15 WBCs per cu.mm. (30 per cent PMNs, 70 per cent lymphocytes), 100 mg. of protein per 100 ml., and sugar was not reported. The patient was found unresponsive, without pulse or blood pressure, and was pronounced dead.

CLINICAL DISCUSSION

DR. RUPPERT: This was the first admission for a 66-year-old man who entered with a five-month history beginning with a flu-like syndrome and pain in his hip. We will have a lot to say later about this pain in his hip. We will say now that pain in the hip does not mean that you have a local process in that area. A barium enema indicated a neoplasm and he had an exploratory laparotomy. Nothing was found in the colon, but large retroperitoneal nodes were found which were biopsied and showed chronic nonspecific inflammatory changes. This is somewhat discouraging. We wonder whether this might be diverticulitis with a local inflammatory process or an abscess around the colon. In the past, people have said that diverticulitis is merely inflammation of a diverticulum, but now there is ever-increasing evidence to suggest that this really represents a micro-perforation of a diverticulum with the development

of an abscess. So I am concerned that nothing was found. The hyperplastic nodes that were found are indeed interesting, and one wonders whether this was not the mass they felt on physical examination. Four months later then, they noticed gas in his hip and this time they found a large abscess in his left hip joint. Then we see that a diagnosis of tuberculosis was entertained and that the patient was treated with chloramphenicol and dihydrostreptomycin.

Now I think we could put some of this together. Suppose that these retroperitoneal nodes had developed an abscess posterior to the psoas muscle. The marked irritation of the muscle could very well produce the pain with movement of his left hip. This psoas muscle rides over the top of the hip joint and the only tissue that separates it from the bone is the psoas bursa. So there is an obvious setup for a direct continuity of an inflammatory process between the psoas abscess and the hip. I think we could guess that these retroperitoneal nodes were involved in the same process in which the colon was involved, and now the involvement of the psoas muscle had extended the inflammatory process to the hip joint.

Two and a half months prior to admission he again developed fever, pain in the area, and went back into the local hospital, was re-explored and had suction applied to the abscess of the hip. Furthermore, one week prior to admission, his chest x-ray and electrocardiogram were compatible with pulmonary emboli. This may mean that the inflammatory process in the left hip region or in the pelvic regions had now involved the common iliac vein and was seeding the lung tissue with multiple septic pulmonary emboli. Another possibility is that these were not emboli. Indeed there are many case reports in which chest x-rays interpreted as pulmonary emboli have turned out to be a metastatic infectious process. We further learn that he received 4 units of blood to maintain his hemoglobin in the range of 7 Gm. Does this mean that he lost it in his gut? or is this a suppression of the bone marrow?

On physical examination the important thing is that he was *chronically* ill. His heart was enlarged but I am going to slip over that.

He had a leukocytosis which later fell to a low normal. His BUN on admission was normal but later became elevated, as did the creatinine. The urinalysis showed WBCs present, as well as granular casts and a trace of protein. He had a total protein of 5.1 with initially a normal albumin/globulin ratio. However, on later serum electrophoresis the albumin was 1.8 and the globulin 3.3. This is significant, suggesting that he may very well have some underlying liver disease, and we notice that later his alkaline phosphatase and his bilirubin rose. His prothrombin time was suppressed. At this point I might mention a couple of other laboratory procedures that would be of importance to us. One would be a bone marrow to differentiate between blood loss and bone

marrow depression. The second would be a liver biopsy since it is one of the common successful means of diagnosing miliary tuberculosis. At this time I might ask Dr. Dunbar if he will discuss with us the x-ray findings.

DR. DUNBAR: This is the pelvic film showing destruction of the joint space of the left hip. The cartilage is largely absent over the upper portion. In addition there are soft tissue gas pockets down in this area as described. I think this rapid destruction of his hip doesn't mean that it took three months for the hip to get this bad. Something like ten days or two weeks would imply rapid destruction. We use this primarily as a differential point between tuberculosis and pyogenic arthrosis. I think this process is more consistent with a pyogenic infection than with tuberculosis because of the marked loss of articular cartilage. Of course also I do not have any evidence of tuberculosis in the chest. Filling of the abscess with contrast media shows some further progression of the septic process in the left hip and outlines the cavity of the abscess in the anterior thigh. There is a pocket where the abscess extends into the thigh, and a large irregular abscess is seen in the pelvis in the area of L-4. I cannot identify spondylitis of the lumbar or lower thoracic spine. I think that we are dealing with an inflammatory disease with widespread abscess formation of the left hip.

The barium enema shows clearly abnormalities throughout the mid-sigmoid which I would interpret as inflammatory, and I think there is a little extravasation of barium into the soft tissues. I would be quite happy with the diagnosis of diverticulitis with limited extravasation of contrast media.

His later chest film shows cardiac decompensation with increase of heart size, increased pulmonary vascularity, and beginning infiltrate in the right lower lobe. This could be pulmonary congestion as well, because of ventricular failure, but I think it may be inflammatory disease of the right lower lobe. I do not see good evidence of pulmonary embolization.

DR. RUPPERT: So we have seen in the x-rays several things that we expected to find. There were the obvious destruction of the hip, the psoas abscess, and evidence of local diverticular disease in the colon with possible perforation. It is important to remember that the colon is a retroperitoneal organ, consequently we have a beautiful setup for an inflammatory process to originate in this area.

The electrocardiogram shows premature atrial and ventricular contractions and ischemia of the anterior wall of the left ventricle. A man who is 66 years old is entitled to some degree of arteriosclerotic heart disease. Under his stressful situation with fever, leukocytosis, and a chronic recurrent inflammatory process, it may very well be that this is beginning to stress the myocardium. I cannot rule out

the possibility of myocardial infarction but I would prefer not to complicate matters by adding this to the diagnosis.

We see that he spiked temperatures up to 104. If this is tuberculosis, one would wonder as to whether or not he had adrenal involvement with severe hypotension and an Addison's crisis. But up to this point I would say that everything we have talked about is compatible with diverticulitis with abscess formation, psoas abscess, and septicemia. We have a local abscess which we were unable to drain, and everything we have seen to date we could blame on a recurrent infectious process with septicemia. During his hospital stay the patient deteriorated rapidly. He had an unexplained episode of respiratory arrest. He had weakness of his right arm suggesting that perhaps the brain had become involved in whatever we are dealing with. Finally, he had bright-red bleeding from the abscess cavity, pleural effusion, some left-sided flaccid paralysis, and died with cardiac arrest.

Now I think we can attempt to put it all together. We are dealing with a 66-year-old man who had a five-month history of hip pain, weight loss, inflammation with biopsy of nodes; who developed pneumonitis with effusion which may or may not have been due to pulmonary emboli; who had cardiomegaly and later suffered respiratory arrest and then a cardiac arrest. On the initial examination a questionable abdominal mass was found and a psoas abscess was discovered complicated by pyarthrosis. From his laboratory studies as well as the clinical findings we know that we are dealing not only with a local process within his abdomen but that other systems were involved. He had pleural effusion as well as some pneumonic infiltration of his lungs which may have been either emboli or infectious. He had renal involvement, because we see increased white blood cells, proteinuria, and later on rise in creatinine. He also had hepatic involvement because we see an elevation in the alkaline phosphatase, elevation of the bilirubin, and a reversal of the A/G ratio. And lastly he must have had CNS involvement leading to respiratory arrest.

I would say that the most likely diagnosis was an infectious process with a focal abscess formation and septicemia which we were unable to bring under control and which led later to the development of local findings in other organs. It may very well be that we are going to find multiple brain abscesses in this patient, or multiple hepatic abscesses, as well as renal abscesses.

So my first diagnosis on the percentage basis would have to be "straightforward" abscess formation with chronic and recurrent septicemia and with multiple system involvement and death. The second diagnosis that I would have to consider in this patient is tuberculosis, this because of the prolonged destruction of the hip joint and because of this pa-

tient's colon and pulmonary involvement. I think that on the basis of the information at hand I cannot rule it out. The smears may be negative, the cultures may not have been given sufficient time, the PPD may be negative, the chest x-ray with the infiltrating process could be T.b., the pleural effusion could also be related to T.b., and the hypotension could be related to adrenal involvement.

There are other possibilities to consider and I will just mention that it could be a *Salmonella* infection, but he should have primarily CNS symptoms followed later by the abdominal pain and marked hepatosplenomegaly. One of the other intriguing thoughts would be brucellosis. If this were brucellosis one would find hyperplastic nodes throughout. Biopsy of these nodes would merely show a nonspecific inflammatory process. Brucellosis can also be chronic and relapsing but the mortality is very low. We could think of cryptococcosis, blastomycosis, or mucormycosis, but we have no evidence of diabetes, of abnormoplegia, or of acute diffuse cerebrovascular disease early in the game. I think that primarily my diagnosis would be that of a systemic infection with *Pseudomonas* and *Proteus* secondary to perforation of a diverticulitis with psoas abscess formation. I cannot rule out at this point tuberculosis of the gastrointestinal tract with miliary T.b.

General Clinical Discussion

DR. PERKINS: Sepsis associated with large abscesses in my experience has not been associated with embolic phenomena. How do we account for focal embolization in a 66-year-old man?

DR. RUPPERT: Of course the other thing we have to consider is, Did he have a subacute bacterial endocarditis? Did he have vegetations in his heart and is throwing emboli from there? We have no history of heart murmur. I just excluded it from the possible causes although it should be a consideration.

DR. PERKINS: I want to ask Dr. Schoenfeld how difficult it is to make a diagnosis of endocarditis in the elderly.

DR. SCHOENFELD: It is sometimes very difficult, particularly if they have fever from other causes. Most elderly people *do* have heart murmurs. I would expect the heart to enlarge a little bit.

DR. PERKINS: As his heart did?

DR. SCHOENFELD: Yes. I think there is nothing incompatible here with his having a bacterial endocarditis.

DR. GREENBERGER: The patient's jaundice might have been due to absorption of bilirubin pigments from the hematoma. In the absence of positive blood cultures or obvious evidence of SBE, he might also have had nonbacterial thrombotic endocarditis (marantic endocarditis) that might account for some of these embolic phenomena.

DR. RUPPERT: There has been disagreement about whether this exists, but it is usually associated with carcinomatosis.

DR. BROWNING: The evidence against T.b. is rather strong. It is true that in certain types of T.b. there is a temporary anergy to tuberculin, but this isn't the type of case that I would ordinarily associate with that. This was a chronically ill person and if this had been T.b. at the time of admission I would expect him to react.

DR. VON HAAM: Is *Proteus* a very dangerous organism?

DR. PERKINS: The *Proteus* species cause a lot of deaths. He had a strain that is relatively sensitive to many antibiotics including penicillin.

DR. RUPPERT: To me, there is no question about the presence of a pyogenic infection, but does he have something else? I chose T.b. because it can hide itself in the presence of this type of infection.

CLINICAL DIAGNOSIS

1. Diverticulitis with perforation.
2. Psoas abscess with pyarthrosis.
3. Septicemia with involvement of lungs, liver, kidneys, and brain.

PATHOLOGIC DIAGNOSIS

1. Diverticulitis with perforation.
2. Psoas abscess with pyarthrosis.
3. Bacterial endocarditis.
4. Cerebral abscess.
5. Septic infarcts in spleen and kidneys.
6. Septicemia (*Proteus mirabilis* and *Escherichia*).

DISCUSSION OF PATHOLOGY

DR. VON HAAM: The body was emaciated and slightly jaundiced. It showed evidence of a recent tracheostomy and colostomy, and a sutured incision in the left inguinal area. Close to the latter a sinus was present draining grayish-black fluid. The peritoneal cavity showed numerous small abscesses between adherent loops of small intestine and contained 300 ml. of turbid serosanguineous fluid. The heart was normal in size. The aortic valve showed large friable vegetations attached to each leaflet. There was no evidence of previous deformity of the valve or of distortion of the other valves. The lungs contained some emphysematous blebs and were moderately edematous. The spleen was enlarged to twice the normal size and contained one recent infarct and one abscess sealed to the peritoneum.

The descending colon was adherent to a large retroperitoneal mass and contained two small diverticula, one of which communicated directly with a small abscess in the peritoneal cavity, while the other led to the large abscess involving the left psoas muscle. The latter abscess extended up to L-4 ver-

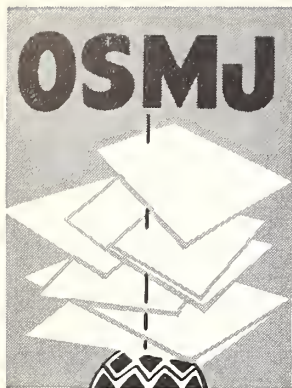
tebra and through the inguinal canal into the thigh, where it had perforated through the skin. The abscess cavity was filled with foul-smelling blackish material. It contained a portion of the external iliac artery, which appeared ligated, and communicated through a small fistula with the previously mentioned diverticulum of the descending colon. In the hip area the abscess involved and had partially destroyed the left hip joint including the acetabulum and the head, neck, and proximal portion of the shaft of the femur.

Both kidneys appeared swollen and the right kidney contained a recent dark-red infarct. The meninges appeared clouded and there was evidence of purulent infiltrate over the right frontal lobe. Dissection of the brain disclosed a large abscess in the right posterior frontal area filled with necrotic material which had apparently broken into the lateral ventricle.

The histologic examination confirmed the presence of an ulcerated diverticulum which communicated directly with the large psoas abscess by a purulent sinus tract filled with pyogenic granulation tissue. The abscess was lined by a well-formed abscess membrane and was filled with necrotic debris. The wall of the femoral artery was also covered with similar pyogenic material.

Examination of the vegetations of the heart showed clusters of fibrin moderately infiltrated with leukocytes and contained numerous colonies of gram-negative bacilli. Similar bacterial colonies were also found in the infarcted areas of the spleen and kidneys. The liver cells were degenerated and showed intracellular bile stasis. Sections of the brain revealed a recent hemorrhagic abscess containing numerous bacterial colonies. The abscess had an ill-defined membrane and was surrounded by purulent encephalitis. The meninges showed a purulent exudate.

In conclusion, we can state then that the clinical diagnosis was correct except that they did not find the "missing link" between the primary pyogenic focus and the metastatic pyogenic lesions which they suspected. This missing link was an acute bacterial endocarditis, which was the source of the multiple emboli. The causative organism was most likely *Proteus mirabilis*, which seemed to resist all the antibiotic therapy that the patient was subjected to. The jaundice can be explained as a combination of toxic degeneration of the liver and the increased destruction of hemoglobin in the abscess cavity. The involvement of the brain was much more severe than the clinical symptoms indicated, but it is very possible that by this time the patient was too far in extremis to permit an exact neurologic examination. The patient's anemia was due to the blood loss which he suffered by direct hemorrhage into the abscess cavity and by the hemolytic component of his septicemia.



NEWS AND *Organization Section*

Proceedings of The Council...

Report of Matters Discussed and Actions Taken At Meeting in Columbus on September 16 and 17

A REGULAR MEETING of The Council of the Ohio State Medical Association was held at Stouffer's University Inn, 3025 Olentangy River Road, Columbus, Ohio, September 16-17, 1967. Those present on Saturday, September 16, were: All members of The Council; Mr. Wayne E. Stichter, Toledo, OSMA legal counsel; Mr. David B. Weihaupt, Chicago, AMA Field Representative; Mr. Charles H. Coghlan, Columbus, Executive Vice President, Ohio Medical Indemnity, Inc.; Dr. Emmett W. Arnold, Columbus, Director, Ohio Department of Health; Dr. Robert E. Tschantz, Canton, AMA Delegate and Chairman of the OMI Liaison Committee; AMA Delegates: Dr. John H. Budd, Cleveland, Chairman of the Delegation; Drs. Richard L. Meiling, Frederick P. Osgood, Charles A. Sebastian, Carl A. Lincke, Edmond K. Yantes; AMA Alternates: Frank F. A. Rawling, Horatio T. Pease, Robert S. Martin, Harry K. Hines, Henry A. Crawford; Messrs. Page, Edgar, Gillen, Campbell, and Moore, of the OSMA Headquarters Office.

Those present on Sunday, September 17, were: All members of The Council except Dr. Robert E. Howard, Cincinnati, President, and Dr. Sanford Press, Steubenville, Councilor of the Seventh District. Others attending were: Mr. Wayne E. Stichter, Toledo, OSMA legal counsel; Mr. David B. Weihaupt, Chicago, AMA Field Representative; Drs. John H. Budd, Robert E. Tschantz, Frederick P. Osgood, Carl A. Lincke, AMA Delegates; Drs. Frank F. A. Rawling, Horatio T. Pease, Robert S. Martin, Henry A. Crawford, AMA Alternates; Mr. James S. Imboden, Columbus; Messrs. Page, Edgar, Gillen, Campbell, and Moore, of the OSMA staff.

Minutes Approved

The minutes of the meeting of The Council held July 26, 1967 were approved by official action.

Membership Statistics

Mr. Page presented membership statistics as follows: OSMA membership as of September 15, 1967 was 10,028, compared to a total membership of 9,999 on September 15, 1966. Of the 10,028 members, 8,801 were affiliated with the AMA.

The Council approved the acceptance of Dr. Robert T. Stone, Akron, as a "new member" of the Association, making him eligible for prorata dues.

Policy on Waiver of Dues for 1968

By official action, The Council adopted the following policy with respect to waiver of annual dues for the calendar year 1968:

(A) That dues for new members in practice, affiliated with the OSMA during the last six months of the calendar year 1968, namely, July 1 to December 31, inclusive, shall be \$25.00, one-half the regular per capita dues of \$50.00. The prorating of dues shall not apply to former members re-affiliating.

(B) That the following procedures shall apply during 1968 with respect to OSMA annual dues of members on temporary military service and not making military medicine a career.

(1) State Association dues for 1968 shall be waived for members on temporary military service and not making military medicine a career.

(2) State Association dues for 1968 shall be waived for physicians who were members of the Association in 1967 and who enter such services during the calendar year 1968 before the payment of 1968 dues.

(3) A refund of membership dues will not be made if a member enters such services in 1968 after his 1968 dues are received at the Columbus office of the Association:

(4) The secretary-treasurer of each county medical society shall be requested to cooperate with the Columbus office in assembling the names of physicians entitled to waiver of dues under the foregoing provisions.

(C) Annual Ohio State Medical Association dues for 1968 for a physician serving in an internship or residency program approved by the AMA Council on Medical Education who meets the membership eligibility requirements of the OSMA and who is accepted into membership by a component medical society shall be \$7.50. Such intern or resident shall be entitled to receive *The Ohio State Medical Journal* as a part of his membership privileges.

First Aid Station for Ohio Legislature

A proposal from the Columbus Academy of Medicine with regard to a first aid station for the Legislature was submitted by Dr. Fulton. The Council expressed appreciation to the Academy for its excellent proposal and made the following suggestions with regard to amendments:

1. That the nurse on duty at the first aid station at all times be a State employee.
2. That such nurse be oriented to procure physician assistance when necessary through the Academy's doctor of the day program or through previous arrangements with the emergency rooms.
3. That the first aid room equipment be provided by the State of Ohio.

New Councilor in Eighth District

The resignation of Dr. James A. Quinn, Jr., Newark, as Eighth District Councilor was accepted with regret. The Council appointed Dr. William M. Wells, Newark, to serve in that capacity until the next meeting of the House of Delegates, May 17, 1968.

Report on Ohio State University College of Medicine

Dr. Meiling reported on the past six years of the Ohio State University College of Medicine, supplementing a printed publication entitled "Years of Change, Years of Progress, 1961-1966."

He discussed several faculty recommendations with regard to proposals for advancing the training for family practice. One would involve an around the clock family practice service staffed by physicians

Dr. Wells Appointed to Serve As Eighth District Councilor

The Council of the Ohio State Medical Association at its meeting on September 16-17 appointed Dr. William M. Wells, of Newark, as Councilor of the Eighth District, to serve in that capacity until the 1968 OSMA Annual Meeting and the regular



Dr. Wells

meeting of the House of Delegates. He succeeds Dr. James A. Quinn, also of Newark, who resigned from that position because he is leaving the state. Dr. Quinn has become associated with a group of pathologists in Tulsa, Oklahoma.

A general practitioner in Newark, Dr. Wells has been in the Licking County seat since 1949. He is on the senior staff of Licking County Memorial Hospital, at present is chief of staff, and for six years has been a member of the Board of Trustees of the hospital.

An active participant in medical organization work, Dr. Wells is a past president of the Licking County Medical Society, and on the state level has served on the OSMA Committee on Care of the Aging and on the Committee on Government Medical Care Programs. He also has served on the Committee on Industrial Medicine.

He is a member of the Board of Directors and the Executive Committee of the Ohio Citizens Council for Health and Welfare.

Dr. Wells is a native of Columbus, and received his undergraduate training at Ohio State University, where he remained to receive his medical degree from the OSU College of Medicine in 1942. Internship was at University Hospital in Columbus.

After three years of active service in the Army Medical Corps during World War II, he returned to University Hospital for a year of residency training in surgery.

Dr. Wells is married and has three sons and a daughter.

from a family practice service faculty in the Department of Preventive Medicine. It would be anticipated that patients sent to this service would become patients of the physician responsible at the time of the patient's entry. Medical students would be assigned to this service and would be taught the business aspects as well as the medical aspects of the operation.

Dr. Meiling reported that another proposal involves research and investigation in the development

of new methodology of delivering health services to the patient.

A third proposal would involve total community health services being provided by the medical school faculty. Examples are the proposed programs in Boston, Baltimore, and St. Louis.

Dr. Meiling also discussed developments under the comprehensive health planning program of the Federal government.

Ohio Medical Indemnity, Inc.

Dr. Tschantz, chairman, reported for the Ohio Medical Indemnity Liaison Committee. The following were appointed by the President to the Nominating Committee to select nominees for the OMI Board of Directors: Dr. Robert N. Smith, Toledo, Chairman; Dr. Richard L. Fulton, Columbus; Dr. Paul N. Ivins, Hamilton.

OMI Will Study Broader Coverage

Dr. Yantes reported that the Research Committee of Ohio Medical Indemnity has been conducting a study of the feasibility of broadening the coverage now provided by OMI and asked The Council for its views and recommendations with regard to this program. There followed an extended discussion after which on motion by Dr. Smith, seconded and carried, The Council recommended that OMI carry on a feasibility study with regard to the expansion of coverage under its policies.

American Medical Association

The Council approved President Howard's recommendations to the AMA for appointments of the following physicians to AMA Councils and Committees: Dr. David A. Chambers, Cleveland, Disability Insurance Review Committee; Dr. Charles H. McMullen, Loudonville, Joint Committee on Health Problems in Education of NEA and AMA; Dr. John H. Budd, Cleveland, Planning Committee; and Rex H. Wilson, Akron, Council on Occupational Health.

Report of AMA Delegates

Dr. Budd submitted in writing a report of the June, 1967 annual convention of the AMA in Atlantic City. A summary appears on page 1075 of the August, 1967 issue of *The Ohio State Medical Journal*.

The Council authorized the AMA delegates to proceed with the development of resolutions on the following subjects:

1. Recommendations for a serious study of the voluntary health insurance, since emphasis has shifted from the financing of health care to the organization of health care.

2. Proposal for the study of the utilization of physicians by the government, including determina-

tion of where waste occurs, with due consideration to the civilian population requirements.

3. Recommendations for amendments to Title XIX. Officers of the delegation were re-elected.

Enthusiastic approval by The Council was given the delegates' recommendation that Dr. Carl A. Lincke, Carrollton, be nominated and supported in June, 1968, for the position of vice president of the American Medical Association. Dr. Lincke is a past president of the Ohio State Medical Association, past chairman of the AMA Council on Scientific Assembly, and an AMA delegate since 1946.

Ohio Director of Health Reports

Dr. Arnold reported to The Council with regard to the activities of his department.

He announced the passage of an air pollution control bill in the recent Ohio General Assembly, with the administration to be located in the Ohio Department of Health. Also passed, according to Dr. Arnold, was a solid waste disposal law, with regulations to be developed by the Ohio Public Health Council; amendments to strengthen the water pollution control law; and legislation on tuberculosis control.

He announced that cases of measles have dropped sharply in the nation and in Ohio, and that 381,000 children susceptible to measles were immunized last year. Dr. Arnold told The Council that many children are not yet protected against polio and that 200,000 doses of oral vaccine will be distributed to physicians and public health authorities. He noted an increase in mosquito-borne diseases and venereal diseases.

He told The Council that the Ohio Health Commissioners' Conference has asked the Ohio State Dental Association for support of a mandatory water fluoridation law for Ohio. He revealed that the Ohio State Medical Association also will be asked to support this proposal.

Comprehensive Health Planning

Dr. Arnold discussed comprehensive health planning which has been assigned to his department for coordination purposes by the Governor. He revealed that a plan has been submitted and that he has hired a chief of the Ohio Department of Health Office of Planning, who will take office November 1, 1967. This official will work with the State Health Planning Council, which will be appointed at a later date.

Health Referral Service

The Council authorized the President to notify the Ohio Department of Health of the endorsement by the Association of the Ohio Health Referral Service and to offer the cooperation of the Association in the work of that agency.

Generic Prescribing

After considerable discussion of developments with regard to proposals for generic prescribing, The Council adopted the following statement with regard to this matter:

OSMA Policy on Generic Prescribing

1. The prime consideration in the choice of a drug is its medical effectiveness.
2. Physicians should be encouraged to supplement medical judgments with cost consideration in making the choice of a drug.
3. The selection of the drug cannot be delegated to persons other than the attending physicians.

Today's Health

The Council voted to continue its traditional project of sending subscriptions to *Today's Health* to all Ohio colleges.

AMA-ERF

The Council authorized the AMA-ERF Committee to proceed with its campaign of raising funds in Ohio.

Workmen's Compensation

The Executive Secretary informed The Council of the appointment of Jay C. Flowers as administrator of the Bureau of Workmen's Compensation. Mr. Campbell reported on workmen's compensation developments.

The Council approved the report from the Stark County Medical Society with regard to a workmen's compensation case in that area.

Legislation

Dr. Howard and Mr. Edgar revealed developments in Congress with regard to H.R. 1280 and other pending bills.

The Executive Secretary presented a comprehensive review of the work of the 107th Ohio General Assembly. He reported that four of the six bills sponsored by the Ohio State Medical Association were successfully passed and were signed into law by the Governor of Ohio. No legislation inimical to the quality of medicine and the public health was passed. A number of bills were amended to meet the objections of the Ohio State Medical Association and two bills were killed due to the efforts of the Association. Mr. Page praised the speaker of the House and the president pro tem of the Senate for their effective leadership and for their selection of excellent officers and chairmen of the Assembly committees.

Ohio Administration on Aging

The Executive Secretary was authorized to send to each county medical society a questionnaire devel-

oped by and requested by the Ohio Administration on Aging.

Thoracic Surgeons in Ohio

With regard to a communication from Dr. Norman H. Baker, Columbus, The Council expressed the opinion that there was no objection to the organization of a state society of thoracic surgeons, providing they work through the Ohio State Medical Association and meet during the OSMA Annual Meeting.

Committee Reports

Ohio Cancer Coordinating Committee, Inc.

Minutes of the meeting of the Ohio Cancer Coordinating Committee, Inc., Held June 7, 1967, included a progress report on the Ohio Tumor Registry Survey and the request that the OSMA District Councilors encourage the upgrading of existing registries and the establishment of new registries where indicated.

Approval of the minutes also included approval of the proposal that the Coordinating Committee seek representation on the Ohio State University Heart, Cancer and Stroke Regional Planning Project; also, that the committee seek representation on the medical advisory boards of the Ohio Valley Program, the Toledo based program and the Cleveland based program. The report was accepted for information.

Rural Health

Approval of the minutes of the meeting of the Committee on Rural Health held July 19, 1967, included the appropriation of \$600.00 for the printing of the revised 4-H Club Personal Health Record booklet.

Postgraduate Institute for Athletic Injuries

Mr. Gillen announced that 60 physicians participated in the August 16-17 Postgraduate Institute for Athletic Injuries, sponsored by the Joint Committee on Athletic Injuries Prevention and the Ohio High School Athletic Association. The report was accepted with commendation.

Insurance Committee

Mr. Campbell presented the minutes of the meeting of the Insurance Committee held July 30, 1967. Approval of the report included the committee's recommendation that the OSMA not endorse any particular Keogh retirement plan, and that no further action be taken on the subject by the committee unless it is directed to do so by the OSMA Council.

With regard to a proposal concerning in-hospital income insurance, The Council supported the committee's recommendation that until the matter of the "coordination of benefits" has been fully decided, now

is not the time to consider additional group coverage for OSMA members.

Also approved was the committee's recommendation that, in view of investigations of other coverages made during the past year, the Blue Cross coverages for OSMA employees be upgraded.

Maternal Health

The Council approved and authorized for publication in *The Ohio State Medical Journal* the second revision of "Guiding Principles for Obstetrical Care" of the Committee on Maternal Health.

OSU Student AMA

The Ohio State University Student AMA publication *SAMAntics* and the assistance provided by the Ohio State Medical Association was then discussed. The Council voted to allocate \$350.00 to the publication each time it is issued during the 12 months subsequent to September 16, 1967, with a limit of four issues.

Male Nurse Anesthetists

A communication with regard to male nurse anesthetists was discussed by The Council. The Executive Secretary was instructed to obtain an opinion of the Ohio State Medical Board and to notify the Ohio Society of Anesthesiologists.

Ohio State Medical Board

The Council voted to support a proposal to raise the salary of the executive secretary of the State Medical Board to the proper category.

Project Vietnam

The Council authorized the appointment of an ad hoc committee to promote the project Vietnam in Ohio and suggested possible candidates for the chairmanship of such a committee.

Audiometric Techniques

The Council reviewed a communication from the Ohio Industrial Nurses Association, asking the cooperation of the Association with regard to the selection of locations and instructors for training courses in audiometric techniques. The Council expressed no objection to the program and suggested that the Association ask the support of the Ohio Ear, Nose and Throat Society in assisting them in the implementation of the courses.

New Dates for Future Meetings

Previously established meeting dates of The Council were revised and it was decided to hold the next two meetings on November 4-5, 1967 and December 9-10, 1967.

There being no further business, The Council adjourned.

Attest: HART F. PAGE
Executive Secretary

Man Fouls the Air He Must Breathe with Tons of Aerial Garbage

Reports of a number of studies state that 130 million tons and more of so-called aerial garbage is being emitted into the air in the United States each year. About 65 million tons of this amount is carbon monoxide; 25 million tons is sulfur oxide; 15 million tons, hydro-carbons; 12 million tons, particulate matter; 8 million tons, nitrogen oxides; and four million tons of other gases and vapors.

It is evident from the above that the air man breathes is polluted. The major part of this pollution is a result of man's activities, such as; the burning of fuels to heat the home, to create energy, to use motor vehicles, and chemicals used or released.

The air is a mixture or combination of liquids, gases, and particles. It is an envelope surrounding the earth. The same amount or quantity of air is not always available in all areas, but is dependent, among other things, upon the meteorological and geographical conditions which influence the airshed, the rate of diffusion, and the concentration of the air pollutants. Pollution may vary from area to area, from one season to another, and from day to day. Some of the conditions and factors that may affect the degree of pollution at any one time or place are the kinds of pollutants, amount of pollutants, speed of the wind, and its direction, topography, sunlight, precipitation, and the increase and decrease of temperature with height.—By I. C. Riggins, M.D., Amherst—One of a series of briefs presented in behalf of the OSMA Committee on Environmental and Public Health.

AMA Schedules National Conference On Emergency Medical Services

"The Community and Emergency Medical Services" will be the theme of a national conference sponsored by the American Medical Association January 18-20, 1968, at the San Francisco Hilton Hotel, San Francisco, California.

During the 2½ day program all aspects of a community's emergency medical services system will be discussed in terms of identification, coordination, and implementation. This system includes: first aid and emergency care, transportation of the ill and injured, emergency communications, and emergency facilities.

Special emphasis will be placed upon the development of Community Councils on Emergency Medical Services and ways and means of financing the community's emergency medical services system. Roles of the U.S. Department of Transportation, Public Health Service, state government and organized medicine also will be discussed.

Consider Your Medical Assistant...

Here Is a Group That Can Help Her Keep Ahead of the Changing Medical Times, and Exchange Ideas with Her Peers in the Field

THE PHYSICIAN OF TODAY wants his patients to think of him in terms of present-day practice, and he wants his medical assistant to reflect his image in a setting of modern medicine.

The progressive medical assistant is constantly striving to update her training — professionally and in terms of her business and socio-economic environment. The Ohio State Society of Medical Assistants, now in its tenth year, is dedicated toward helping the medical assistant to better equip herself for her job and to promote a spirit of service and loyalty in the doctor's office.

Here are some pointers, Doctor, on what the Ohio State Society of Medical Assistants may mean to your medical assistant — and to you.

- Twenty years ago many physicians found little need for a medical assistant. Today few doctors' offices are without one or two and the medical assistant is important in the medical team.

- In the past, the medical assistant usually was recruited from the ranks of hospital personnel because of her experience with patients and familiarity with medical problems. She kept up-to-date on changes through the doctor's coaching and through her professional associations.

- Today's medical assistant may be grounded primarily in the business world, a field with which the doctor is not familiar. The OSSMA can be of great help to her.

- In the past, the nurse-assistant, perhaps between minor surgical procedures and frequent house calls with the doctor, found time to answer the telephone, do some bookkeeping, and write a few letters. Today tax problems alone demand a sophisticated approach to office procedure and a girl who can assume responsibility on business matters.

- The ever increasing demand for office bookkeeping, administrative work, typing of patients' records, filling out of forms, etc., places greater emphasis on the girl trained in office procedure.

- In the past, the physician's payments for professional services were handled informally. The modern medical assistant sees that her employer is paid for his professional services without destroy-

ing the patient's initial sense of gratitude for his restored good health.

- The modern medical assistant must keep the office running smoothly with proper scheduling of patients' examinations and treatments. She must be unruffled by the inevitable emergency which turns her perfect schedule into chaos. An exchange of ideas in this field with other medical assistants is helpful.

- The medical assistant must be diplomatic and tactful in her dealings with patients — something she learns, not from books, but through her willingness to understand people. Here also the OSSMA can be helpful.



- The dedicated medical assistant of today joins with her employer in his constant endeavor to make the practice of medicine more efficient and progressive. This spirit is in keeping with principles of the OSSMA.

- The dedicated medical assistant finds satisfaction in the accomplishments of a team — with her doctor as captain. This too is in keeping with teachings of OSSMA.

The Ohio State Society of Medical Assistants is approved by the Ohio State Medical Association, and is guided by an OSMA Advisory Committee.

Physicians and medical assistants are urged to correspond with the Ohio State Society of Medical Assistants. Membership chairman is Mrs. Wilda Haines, Aultman Hospital, 2600 Sixth Street, S. W., Canton, Ohio 44710. The President is Miss Laura L. Lockhart, 21 South Highland Avenue, Apt. 6, Akron, Ohio 44303.

Refer to the September issue, page 1223 for the initial article on this subject and watch future issues for still more information.

Roundup of Medical Legislation in The Ohio General Assembly

By HART F. PAGE

OSMA Executive Secretary

THAT PERIOD of the 107th Ohio General Assembly ending September 8 was led by a vigorous group of young men who "didn't know it couldn't be done." Senator Theodore M. Gray, young President Pro Tem of the Ohio Senate who had already proven his ability in the 106th Ohio General Assembly, was joined by another young man, House Speaker Charles F. Kurfess, who brought into office with him a team of experienced and knowledgeable young men: Robert E. Holmes, Majority Leader; Robert I. Evans, Majority Whip; Keith McNamara, Chairman of the Reference Committee; Robert E. Levitt, Judiciary Chairman, and many others. The Democrats, too, chose a young man to lead their side of the House—Frank R. Pokorny, an able leader from Cleveland.

For medicine, this was an historical session. Never had medicine asked for so much positive legislation to

bills which would harm the public health or standards of care were passed by this legislature.

Medical Practice Act

The first broad revision of the Medical Practice Act in over a half century, H. B. 418, introduced by Rep. Keith McNamara of Columbus, becomes law, effective December 1, 1967; Injunction Procedure January 1, 1969. See complete article on page 1508.

Body Donation Bill

A landmark bill with regard to the advancement of medical science and art was House Bill 215, introduced by Rep. Carl B. Stokes of Cleveland, to permit a living person to donate his body or any part of it for medical purposes. Effective November 24, 1967. See complete article on page 1506.

Utilization Committee Protection

Of great assistance to physicians is the successful passage of House Bill 801, introduced by Rep. Charles E. Fry of Springfield, to protect physicians who, acting in good faith, turn over information on patients to utilization review committees. This bill also protects physician members of utilization committees in the carrying out of their responsibilities. The law becomes effective December 4, 1967. For complete article see page 1505.

Podiatry Clarification

Anticipated to be of great assistance in the enforcement of the Medical Practice Act is the clarification legislation on podiatry. An amalgamation of House Bill 662 (Hughes et al) and House Bill 747 (Kohnen-Galbraith) and retaining the number 662, the new law will restrict the podiatrist in his work with the hand, permitting him to treat superficial hand lesions only, and eliminating those associated with trauma. Under the new law, the podiatrist may treat the local manifestations of systemic diseases as they appear in the foot, but the patient must be concurrently referred to a physician for the treatment of the systemic disease itself. Effective date is December 14, 1967.

Senator Cook Guides Medical Measures

The Medical Practice Act, Body Donation Bill, and the Utilization Committee Bill all were guided through the Ohio Senate by Senator Howard C. Cook, of



Representative Keith McNamara, of Columbus, introduced H. B. 418, which brought about the first broad revision of the Medical Practice Act in over a half century. The bill was sponsored in the Ohio General Assembly by the OSMA. Representative McNamara, as chairman of the Reference Committee, served in a key leadership position of the Ohio House of Representatives.

protect the public health and raise the standards of medical care for Ohioans. At the instruction of The Council, the staff carried to the General Assembly the largest package of medical legislation ever proposed. Fortunately, for the Ohio public and the profession, most of the package was adopted. In addition, no

Toledo, who became acquainted with the legislation as it was heard in the Senate Judiciary Committee.

A member of that committee, an able attorney and an enthusiastic and energetic public servant, Senator



Senator Howard C. Cook, Toledo, capably guided three OSMA-sponsored bills through the Ohio Senate: H. B. 215, to permit living persons to donate their bodies or parts thereof for medical purposes; H. B. 418, to revise the Ohio Medical Practice Act; and H. B. 801, to protect members of utilization review committees and physicians who furnish data to utilization review committees. Senator Cook also introduced legislation for the new medical school in Toledo, naming it the Medical College of Ohio at Toledo.

Cook was an outstanding senator in the recent session of the 107th Ohio General Assembly.

Health Committee Veterans

Veteran house members who served well on the Health and Welfare Committee included Carlton Davidson, Ironton, chairman; Robert L. Wilhelm, Van Wert, vice-chairman and chairman of the subcommittee on House Bill 418; Frank W. Mills, Dayton; David Weissert, Norwich, a member of the subcommittee on H. B. 418; and Ralph Kohnen, author of the nurse licensure bill and coauthor of the bill to clarify the law with regard to podiatry.

Outstanding "First Termers"

Outstanding among the freshmen on the committee were Rep. John A. Galbraith, Toledo, author of the OSMA-sponsored abortion bill and a member of the H. B. 418 subcommittee; Robert A. Manning, Akron, who was a key member of the subcommittee which studied H. B. 418; Robert G. Jones, Columbus; and Rodney H. Hughes, Bellefontaine, who sponsored the legislation resulting in House Bill 662, which clarified the sections of the law with regard to podiatry. Merged with this bill was OSMA-sponsored House Bill 747 which was carried by Reps. Kohnen and Galbraith.

Also helpful to medicine on the House Health and Welfare Committee were Troy Lee James, Cleveland; Claude M. Fiocca, Akron, who served on the H. B. 418 subcommittee; Michael P. Gamble, Canton; Phale

D. Hale of Columbus, and William F. Bowen of Cincinnati.

Freshmen of great ability other than those serving on the House Health and Welfare included: George E. Mastics of Cleveland, who introduced one of the LSD control bills; George V. Voinovich, Cleveland; Alan E. Norris of Westerville; Richard R. Hollington, Jr., Cleveland; Albert H. Sealy, Jr., Dayton; Thomas E. Hill of Cleveland, author of the Cleveland Academy of Medicine bill to control use of experimental drugs; Mack Pemberton of Columbus; Henry H. Schriver of Lorain, and James R. Weldishofer of Toledo.



House Speaker Charles F. Kurfess was the able leader of the House of Representatives in the 107th Ohio General Assembly which enacted more positive public health and medical legislation than any previous legislature, prior to its recess September 8.

Able Senators

In the Senate, Mr. Gray was ably assisted by veteran legislators including Sen. Max H. Dennis of Wilmington, Judiciary Chairman; Sen. Oakley C. Collins, Ironton, Chairman of Education, Health and Welfare; Sen. Clara E. Weisenborn, Dayton, Vice-chairman; Sen. Robert R. Shaw, Finance Chairman; Sen. Walter E. Powell, Finance Vice-chairman; Sen. Tennyson Guyer, Agriculture and State Agencies Chairman; Sen. Robin T. Turner, Chairman of Elections Commerce and Labor, and Sen. Robert E. Stockdale, Kent, Urban and Highway Affairs Chairman.

Also giving able assistance were Sen. Howard C. Cook, Toledo; Sen. James K. Leedy, Wooster; Sen. William W. Taft, Cleveland; Sen. Harry V. Jump, Willard; Sen. John W. Bowen, Columbus; Sen. Stanley J. Aronoff, Cincinnati; Sen. Paul E. Gillmor, Old Fort; Sen. Harry L. Armstrong, Logan; Sen. Tom V. Moorehead, Zanesville; and Sen. Ralph S. Regula, Navarre.

OSMA Legislative Machinery Functioned Well

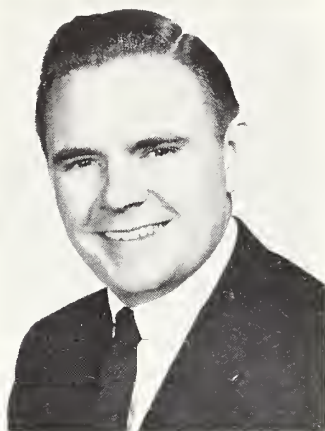
As in the past, a legislative bulletin was issued each Thursday from OSMA headquarters to county medical society officers and legislative committee chairmen.

The bulletins covered the status of medical and

health bills and suggested follow-up procedures in contacting legislators who were home for the weekend.

Special bulletins, wires, and telephone calls supplemented the regular bulletins on key issues at appropriate times.

The work of the legislative machinery of the Ohio State Medical Association and its county medical so-



Senator Theodore M. Gray, President Pro Tem of the Ohio Senate, serving with distinction his second term in that position, provided capable leadership in the Senate of the 107th Ohio General Assembly. This was a legislative session which produced a record number of enactments for positive public health and medical legislation up to the time of its recess September 8.

cieties again proved that the strength of a legislative program depends upon the efficient functioning of local chairmen and society officers, assisted by society members who have the "ear of their legislator."

As has been traditional, all measures in the medical and health field were closely followed by the representatives of the Ohio State Medical Association.

Bills were sponsored, supported, or opposed in accordance with the policies of the Association as determined by the House of Delegates and The Council.

The legislative representatives of the Association were on duty at the State House while committee hearings and House and Senate sessions were under way. Many times accompanied by physician witnesses, they appeared at countless committee hearings, testifying on bills, supplying information, and suggesting amendments for improvement of legislation. Also, there was considerable contact with individual legislators.

LSD Control Law

Effective September 20, 1967, was Senate Bill 74, the Weisenborn Act to prohibit the manufacture, sale, possession, or use of LSD and other hallucinogenic drugs. This bill was supported by OSMA.

The measure provides for forceful penalties for first offenders and severe penalties for subsequent offenders. Any person previously convicted of a similar offense in another state or federal jurisdic-

tion and convicted of a later offense in Ohio shall be considered a subsequent offender.

Nursing Bills Successfully Amended

Bills to provide for the mandatory licensing of professional nurses, H. B. 360, and of licensed practical nurses, H. B. 528, became law after they were amended at the request of the Ohio State Medical Association in two primary categories: 1. the inclusion of a section to protect auxiliary personnel who work under the direction and supervision of a licensed physician, and 2. acts of medical diagnosis or prescription of medical, therapeutic or corrective medical measures by a nurse are specifically prohibited.

Clinical Lab Bill Killed

House Bill 605, to license laboratories and laboratory directors was recommitted to the Senate Education, Health and Welfare Committee to die, after it reached the Senate Floor the last day of the session.

Veteran senators rallied around medical and hospital organizations to kill this measure, after its proponents refused on a number of occasions to consider amendments offered by the Ohio State Medical Association in an attempt to make the measure somewhat acceptable. The Ohio State Medical Association favors legislation for laboratory licensing,



Rep. Ralph B. Kohnen, Jr., Cincinnati, with Rep. Galbraith, introduced OSMA-sponsored H. B. 747, to clarify the podiatry laws. The bill was later amalgamated with H. B. 662, which passed. Representative Kohnen is a member of the House Health and Welfare Committee and chairman of the Criminal Law Section of the House Judiciary Committee.

but H. B. 605, provided double licensing for pathologists, and gave primary authority to the Ohio Department of Health, rather than to the State Medical Board, the logical agency to license professional people and professional practice.

Optometry Bill Fails

House Bill 582, to permit school boards to employ "school optometrists," vigorously opposed by

OSMA and the Ohio Ophthalmological Society, failed to receive the support of the members of the Senate Education, Health and Welfare Committee. The bill was sponsored by the Ohio Optometric Association and supported by the Ohio Education Association and Ohio Association of School Administrators.

The OSMA is of the opinion that the statement of the Vision Conservation Advisory Board of the Ohio Department of Health is appropriate with regard to the unacceptability of this bill:

"The Board feels that the screening test is at best, a rough and incomplete evaluation. Therefore, it is recommended that an eye specialist not give the screening test lest a false sense of security be given the family. On the other hand, vision testing must be done by a qualified and trained person. The screening test can be administered by teachers, technicians, nurses, or volunteers who have received proper training."

This statement refers to vision screening for school children. Present law does not provide for employment of an optometrist by a school board, and such is contraindicated.



Rep. John A. Galbraith, Toledo, was author of the OSMA-sponsored bill to broaden the scope of legally justifiable abortions. This bill made progress and was recommended for passage by the House Health and Welfare Committee, but finally died in the House Rules Committee. Representative Galbraith was active in most OSMA-sponsored legislation. He was a coauthor with Representative Stokes and others of H.B. 215, the body donation bill; with Representative McNamara and others, of H.B. 418, modernizing the Medical Practice Act; and of H.B. 662, with Representatives Hughes and Kohnen, to clarify the statutes governing podiatry.

Abortion Bill Dies in House Rules Committee

House Bill 408, OSMA-sponsored bill to broaden the scope of legally justifiable abortions, was reported out and recommended for passage by the House Health and Welfare Committee by a vote of 8 to 7. The measure died later in the House Rules Committee. This legislation was requested by the action of the OSMA House of Delegates in 1965, and was introduced by Rep. John A. Galbraith of Toledo.

Bill to Protect Scientific Studies Stopped By Reps. Tulley and Bartunek

OSMA-sponsored House Bill 387, introduced by Rep. Charles E. Fry of Springfield, to protect medical research and study records and to permit physicians



Rep. Rodney H. Hughes, Bellefontaine, introduced H. B. 662, to clarify the podiatry laws. H. B. 747 (Kohnen-Galbraith) was amalgamated with this bill, and subsequently the legislation became a law as H. B. 662, effective December 14, 1967. Representative Hughes is a member of the House Health and Welfare Committee.

to furnish data or reports to committees conducting such studies was sent to a House Judiciary subcommittee early in June after having been recommended for passage by House Health and Welfare and then recommitted to the Judiciary Committee when controversy developed on the floor of the House. It died in this subcommittee due to the efforts of two of the members, Reps. Joseph P. Tulley of Willoughby and Allen J. Bartunek of Cleveland, whose proposals for amending the bill were entirely unacceptable to the OSMA.

Other Health Legislation

S. B. 32 — by Senator Weisenborn . . . actively supported by OSMA . . . to provide for the examination of persons suspected of having tuberculosis. **Passed. Effective August 15, 1967.**

S. B. 60 — by Senator Carney, relative to regulating the identity and quantity of commodities packaged in advance of sale at retail. Opposed by OSMA in form introduced. **Indefinitely postponed at session's end.**

S. B. 106 — by Senator Carney . . . to provide medical assistance to certain needy persons . . . opposed by OSMA. **Indefinitely postponed at session's end.**

S. B. 155 — by Senator Taft, to give the Ohio Director of Health discretion as to whether he will accept items requested by the federal government for inclusion on birth certificates . . . supported by OSMA. **Passed. Effective October 31, 1967.**

S. B. 169 — Senator Armstrong et al. — to provide for county boards of mental retardation. **Passed. Effective October 25, 1967.**

(Continued on Next Page)

S. B. 173 — by Senators Guyer and Armstrong . . . relative to optometry and the freedom of choice in utilizing professional services. Amended to meet OSMA objections and passed. **Effective September 26, 1967.**

S. B. 255 — by Senator Weisenborn — to allow county commissioners to enter into agreements with and to pay for the services of boards of health. **Passed. Effective October 31, 1967.**

S. B. 257 — Senator Weisenborn — to permit merger of county and municipal health districts into general health districts. **Passed. Effective November 24, 1967.**

S. B. 258 — Senator Weisenborn — to require licensing of cosmetic therapists by the Ohio State Medical Board. **Passed. Effective December 13, 1967.**

S. B. 303 — by Senator Taft — permits several school districts to join to establish special schools for the handicapped . . . supported by OSMA. **Passed. Effective November 21, 1967.**

S. B. 316 — by Senator Taft — to allow courts to order psychiatric examinations for persons convicted of misdemeanors. **Passed. Effective December 13, 1967.**

S. B. 344 — by Senator Holcomb — to establish a division of psychiatric criminology within the Department of Mental Hygiene and Correction. **Passed. Effective November 24, 1967.**

S. B. 358 — by Senator Weeks — to remove psychotherapy from the list of limited branches of medicine. This bill was opposed by OSMA, since psychotherapy is a part of the practice of medicine and should be practiced only by licensed physicians or by other personnel under the direct supervision of licensed physicians. **Indefinitely postponed at session's end.**

S. B. 420 — by Senator Powell — to establish a board of hearing aid licensing and licensure of hearing aid proprietors, fitters, and students . . . supported by OSMA. This bill was caught in the flood of late session business and was **indefinitely postponed at session's end.**

S. B. 426 — by Senator Cook — to change the name of the Toledo State Medical College to the Medical College of Ohio at Toledo. **Passed. Effective December 9, 1967.**

H. B. 106 — by Reps. Weis & Nixon — to provide for the licensing of hearing aid dealers. Approved in principle by OSMA. **Indefinitely postponed.**

H. B. 127 — Rep. Pemberton et al — eliminates the board of review, consisting of the secretary of the state, auditor, and treasurer of state, created to hear grievances of persons affected by the acts of occupational and professional boards, commissions and agencies; eliminates related grievance procedures. **Passed. Effective November 21, 1967.**

H. B. 178 — by Reps. Galbraith & Quilter — to establish a bureau of mental retardation within the Di-

LEGISLATURE IN RECESS WILL RETURN JANUARY 15, 1968

In lieu of adjournment sine die, the Ohio General Assembly recessed on September 8, 1967 until 8 P. M., January 15, 1968.

Most bills remaining in committees at the time of recess were indefinitely postponed. However, the House kept alive and will carry over in rules or in standing committees some 75 bills and two resolutions. The Senate will carry over four bills and three resolutions.

vision of Mental Hygiene. **Passed. Effective August 24, 1967.**

H. B. 312 — by Rep. Mottl — to prohibit medical quackery. **Indefinitely postponed at session's end.**

H. B. 445 — by Reps. Thorpe and Reichel — to restrict the use of experimental drugs in human investigation. This OSMA-sponsored bill was **amalgamated with H. B. 872.**

H. B. 489 — by Rep. Albritton — OSMA-supported bill to separate the Ohio Department of Mental Hygiene and Correction into two separate departments, based on House of Delegates Resolution of 1966. **Indefinitely postponed at session's end.**

H. B. 500 — by Rep. McNamara — OSMA-supported bill to allow private insurance companies to write workmen's compensation policies in Ohio. **Indefinitely postponed at session's end.**

H. B. 621 — by Reps. Dennison and Mottl — to license medical technologists. Opposed by OSMA and Ohio Society of Pathologists. **Indefinitely postponed.**

H. B. 648 — by Rep. Kohnen et al. — community mental health act. **Passed. Effective October 26, 1967.** Complete analysis in a forthcoming issue of *The Ohio State Medical Journal*.

H. B. 825 — by Rep. Davidson — to require psychiatric tests for persons convicted of child abuse. **Indefinitely postponed at session's end.**

H. B. 872 — Rep. Kerns — relative to the application to sell or dispose of a new drug, from the Director of Agriculture. Amended at the request of OSMA. **Indefinitely postponed at session's end.**

H. B. 888 — by Reps. Stokes & Shoemaker — to require physician's prescription to purchase paregoric. **Indefinitely postponed at session's end.**

H. B. 889 — by Rep. Fry — to license ambulance drivers. **Indefinitely postponed.**

H. B. 911 — by Rep. Fry — to permit the implementation of a standard system of renewing licenses. This bill remains alive for consideration at the January 15, 1968 session of the Ohio General Assembly.

Utilization Review Committees Under Legal Protection of New Legislative Measure

HOUSE BILL 801, OSMA-sponsored bill introduced by Rep. Charles E. Fry, Springfield, to protect physicians who furnish data to utilization review committees and to protect members of utilization review committees in the carrying out of their duties was passed by the Ohio General Assembly August 24, and will become effective December 14, 1967. Mr. Fry was assisted in the House of Representatives by Rep. Joseph P. Tulley of Willoughby.

In the Senate, the bill was handled by Senator Howard C. Cook of Toledo, who also was a member of the Senate Judiciary Committee which heard the bill. Senator Max H. Dennis of Wilmington, as chairman, was of great assistance in the passage of the measure.

The text of the new act is as follows:

(Amended House Bill No. 801)

AN ACT

To enact sections 2305.24 and 2305.25 of the Revised Code to provide immunity to doctors furnishing information to utilization committees and members of such committees.

Be it enacted by the General Assembly of the State of Ohio:

SECTION 1. That sections 2305.24 and 2305.25 of the Revised Code be enacted to read as follows:

Sec. 2305.24. Any information, data, reports, or records made available to a utilization committee of a hospital, or a utilization committee of a state or local medical society composed of doctors of medicine or doctors of osteopathic medicine and surgery shall be confidential and shall be used by such committee and the committee members only in the exercise of the proper functions of such utilization committee. A right of action similar to that a patient may have against an attending physician for misuse of information, data, reports, or records arising out of the physician-patient relationship, shall accrue against a member of a utilization committee for misuse of any such information, data, reports, or records furnished to such committee by an attending physician. No physician, surgeon, institution, or hospital furnishing information, data, reports, or records to any such committee with respect to any patient examined or treated by such physician or surgeon or confined in such institution or hospital shall, by reason of

such furnishing, be deemed liable in damages to any person, or be held to answer for betrayal of a professional secret within the meaning and intent of section 4731.22 of the Revised Code. Information, data, or reports furnished to a utilization committee



Representative Charles E. Fry, of Springfield, introduced OSMA-sponsored H. B. 801, a successful measure which will protect physicians who in good faith turn over information on patients to utilization review committees. He also introduced H. B. 387, to protect medical research data, an OSMA-sponsored bill which died in a subcommittee of the House Judiciary Committee. Representative Fry served as chairman of the House Committee on Government Operations.

of a state or local medical society shall contain no name of any person involved therein.

As used in this section, "utilization committee" is the committee established to administer a utilization review plan of a hospital or extended care facility as provided in the "Health Insurance for the Aged Act," 79 Stat. 313 (1965), 42 U.S.C. 1395x (k).

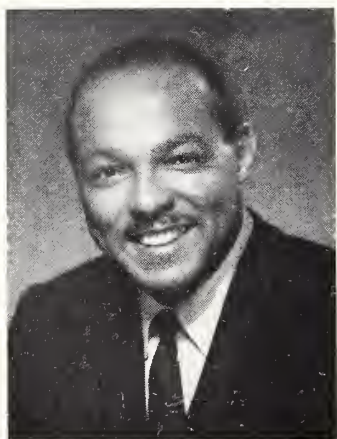
Sec. 2305.25. No member of a utilization review committee of a hospital or of a utilization committee of a state or local society composed of doctors of medicine or doctors of osteopathic medicine and surgery shall be deemed liable in damages to any person for any action taken or recommendation made within the scope of the functions of such committee, if such committee member acts without malice and in the reasonable belief that such action or recommendation is warranted by the facts known to him after reasonable effort to obtain the facts of the matter as to which such action is taken or recommendation is made.

(Turn page for more legislation)

Stokes-Cook Act Is Landmark Legislation for Advancement of Art and Science of Medicine

HOUSE BILL 215, introduced by Representative Carl B. Stokes of Cleveland, has contributed much to the body of law with regard to medical advancement by permitting a living person to make a gift, for medical purposes, of his body or parts thereof after death.

Guided in the Senate by Senator Howard C. Cook, of Toledo, this legislation was signed by the Governor August 25, and will become effective November 24, 1967.



Rep. Carl B. Stokes, Cleveland, introduced H. B. 215, and steered it through the House. The new law permits living persons to will their bodies or organs after death for medical purposes.

Backed strongly by the Ohio State Medical Association, the bill had a stormy path through the House and Senate, where attempts were made to permit the next of kin to enter the picture at the death of the donor—a procedure which would have negated the purpose of the legislation.

Members of the House and Senate who assisted with the passage of the bill are: Rep. Robert A. Manning, coauthor in the House; Reps. John A. Galbraith, Toledo; Richard R. Hollington, Jr., Cleveland; Robert F. Reckman, Cincinnati; Herman K. Ankeney, Xenia; and James P. Celebrezze, Cleveland; and Thomas P. Gilmartin, Youngstown.

In the Senate, the bill was in the hands of a Judiciary Subcommittee consisting of Sen. Howard C. Cook, chairman, and Senators James K. Leedy, Wooster; Paul E. Gillmor, Old Fort; and William W. Taft, of Cleveland. Chairman of the Judiciary Committee which had responsibility for the hearing of the bill is Senator Max H. Dennis of Wilmington.

A previous bill on this subject introduced by Senator Donald Steiner of Canton in 1961 was lost on the floor of the Senate 13-22.

The text of the new law follows:

(Amended Substitute House Bill No. 215)

AN ACT

To enact sections 2108.01 to 2108.03, inclusive, of the Revised Code to authorize a living person to make a gift of his body or parts thereof after death.

Be it enacted by the General Assembly of the State of Ohio:

SECTION 1. That sections 2108.01, 2108.02, and 2108.03 of the Revised Code be enacted to read as follows:

Sec. 2108.01. A person who is twenty-one years of age or older and of sound mind may make a gift of all or any part of his body effective upon his death, by a written instrument signed by him or by some person in his presence and at his express direction and subscribed by two witnesses in the presence of the donor and each other who shall have no affiliation with the donee or the donee institution. Such a gift made in a written instrument is effective without delivery or acceptance and may be revoked in the same manner as executed. If the entire body has been donated, next of kin may arrange funeral services or other last rites before the body is claimed by the donee.

The rights of a donee or his agent under such a gift are superior to those of any person claiming as spouse, relative, guardian, or in any other relationship, as such rights may be limited by the instrument of donation.

A gift made under this section, in addition to the authorizations contained in the instrument of gift, authorizes the donee or his agent to perform only the surgical procedure necessary to carry out the gift. A donee may employ or authorize any licensed physician or surgeon to carry out necessary surgical procedures. When the gift is of only a part or parts of the body, immediately following the removal of the part or parts named, custody of the body shall be transferred to the next of kin.

Sec. 2108.02. The following persons may be named as donee in a gift made under section 2108.01 of the Revised Code for the purposes indicated:



Governor James A. Rhodes is shown above signing H. B. 215, a landmark piece of legislation that permits living persons to donate their bodies or organs after death for medical purposes. Joining in the ceremony are legislators, all of whom helped passage of this law. Seated to the reader's left is Rep. Robert A. Manning, and on the right, Rep. Herman K. Ankeney. Standing from left are Rep. R. R. Hollington, Jr.; Senator Howard C. Cook, who was the Senate floor manager of the bill; Senator Paul Gillmor; Senator William W. Taft; and Senator Max H. Dennis, chairman of the Senate Judiciary Committee. Rep. Carl B. Stokes, Cleveland, who introduced the bill, was not present when the picture was taken, nor was Rep. John A. Galbraith, Toledo, who was a coauthor in the House of Representatives.

(A) A licensed physician or surgeon, or a hospital, for medical education, research, the advancement of medical science, aid in therapy, or for transplantation to replace diseased or deteriorated parts of other persons;

(B) A medical school, college, or university engaged in medical education and research, for its educational research or scientific purposes;

(C) A nonprofit blood bank, artery bank, eye bank, or other storage facility for human parts to be used for therapy or transplantation for other persons, or for medical education and research;

(D) A named individual for transplantation or therapy needed by him;

(E) Any licensed physician or surgeon claiming

the body, not naming him, for any of the above purposes.

If the donor so provides in the instrument of donation, in the event transplantation to a named donee is not feasible, removal for transplantation may be made for any person by a licensed physician or surgeon, who is the alternate donee for such purpose.

Sec. 2108.03. A person who, in good faith and acting in reliance upon an authorization made under Chapter 2108. of the Revised Code and without notice of revocation thereof, takes possession of, performs surgical operations upon, or removes tissue, substances, or parts from a human body, or who refuses such a gift, or any person who unknowingly fails to carry out the wishes of the donor according to Chapter 2108. of the Revised Code, is not liable for damages in a civil action brought against him for such act.

(Turn page for more legislation)

McNamara Act is First Broad Revision of Medical Practice Statutes in Half a Century

House Bill 418 Becomes Law December 1, 1967

HOUSE BILL 418, introduced by Rep. Keith McNamara, of Columbus, OSMA-sponsored bill to modernize the Medical Practice Act, was passed by the 107th Ohio General Assembly and becomes law on December 1.

The act constitutes the first broad revision of the statutes governing medical practice in more than a half a century. The original act was adopted in 1896. The osteopaths were added in 1902; the limited practitioners in 1915; in 1943 the unlimited license of osteopathic medicine and surgery was made effective; and in 1959 physical therapy became a part of the act.

Opposition Overcome

The pathway through the House and Senate was a long and difficult one, with barriers erected by the chiropractors all along the way. Legislators favoring good government and proper enforcement of laws to protect the people of Ohio from unqualified practitioners rallied time and time again to make certain of the passage of House Bill 418.

Representative McNamara, chairman of the Reference Committee of the House and an excellent student of medical legislation, fought continuously and well for the bill bearing his name. Senator Howard C. Cook, of Toledo, expertly guided the passage of the bill on the Senate floor, when the vice-chairman of the Senate Judiciary Committee, Senator William W. Taft, of Cleveland (who originally had accepted the assignment) was called out of state on official legislative business.

The bill was processed through the House Health and Welfare Committee, chaired by Rep. Carlton Davidson of Ironton through the fine efforts of a subcommittee headed by Representative Robert L. Wilhelm, of Van Wert, vice-chairman of the House Health and Welfare Committee. Assisting him were Representatives Robert A. Manning of Akron; John A. Galbraith of Toledo; David Weissert, Norwich; Claude M. Fiocca, Akron, and William F. Bowen, Cincinnati.

In the Senate the bill was processed by the Judiciary Committee under the able chairmanship of Senator Max H. Dennis of Wilmington. It was assigned for in-depth study and hearings to a subcommittee of Senator Taft, chairman; Senator Cook, and Senator William B. Nye, of Akron.

Senator Nye proposed amendments that would make refusal to accept Ohio Department of Public Welfare Fees as full payment or refusal to accept "assignment" in welfare cases grossly unprofessional conduct. Opposed by the medical profession the

"Nye Amendments" were rejected by the Judiciary Committee, and when proposed again on the floor by Senator Charles Carney of Youngstown, they were defeated on a party line basis, Republicans voting against, Democrats for.

Summary of Bill

A summary of the bill follows:

4731.10 — Allows for \$10 fee for certifying a licensee to another state.

4731.18 — Permits the board to recognize national examining boards of the appropriate limited branches of medicine for endorsement procedure.

4731.22 — First paragraph clearly spells out that it takes a majority of all members of the board to refuse to grant a license or to revoke or suspend a license.

Violation of Ethics

4731.22(F) — Adds violation of the code of ethics of a given profession to the grounds for suspension or revocation of a license under grossly unprofessional or dishonest conduct.

Mental Incompetency

4731.221 — Authorizes the secretary of the board to file probate proceedings when the board has reason to believe a licensee is mentally ill or mentally incompetent.

Attorney General is to represent the board in any such proceeding.

Provides for suspension of license during period licensee is adjudged to be mentally ill or mentally incompetent.

Protects board from suit by licensee, under such circumstances, except for fraud or bad faith.

4731.222 — Authorizes the board to require licensee to obtain additional training, pass an examination or limit the scope of practice of a licensee whose license has been suspended or is inactive for more than two years.

Exam Fee Increased

4731.24 — Increases fee for examination of medical doctor or doctor of osteopathic medicine and surgery from \$50 to \$75.

Provides that the fee must be paid for subsequent examinations, rather than give free re-examinations as at present.

M. D.'s to Register Every Two Years

4731.281 — Provides for biennial registration on or before January 1 of odd-numbered years of all



Governor James A. Rhodes is pictured signing H. B. 418, the first broad revision of the Ohio Medical Practice Act in over a half century, surrounded by legislators all of whom helped write the bill into Ohio law. Seated on the reader's left is Rep. Keith McNamara, and on the right, Senator Howard C. Cook. Standing, from left, are Rep. Robert L. Wilhelm, Senator William W. Taft, Senator James K. Leedy, Senator Paul Gillmor, Senator Max H. Dennis, Senator John W. E. Bowen, and Rep. Robert A. Manning.

doctors of medicine licensed to practice in this state.

Registration fee of \$10 each time.

The Board shall mail application to each M. D. by October 1 before January 1 of biennial registration.

Provides what information shall be included in the application.

The Board shall issue a two-year certificate upon receipt of application.

A certificate suspended for failure to register shall be reinstated by the board upon submission of registrants last registration certificate plus delinquent and current fees and a penalty of ten dollars.

The Board shall publish biennially a list of all persons licensed as Medical Doctors in Ohio.

4731.29 — Eliminates requirement that Osteopathic physician and surgeon be examined prior to endorsement in Ohio.

Temporary Licensing for Interns, Etc.

4731.291 — Provides for issuance of a temporary license to doctor of medicine or doctor of osteopathic medicine and surgery who wishes to come to Ohio for an approved internship, residency or fellowship.

Application terms are spelled out with an annual

fee of \$10. License is for one year and may be renewed up to a total of five years. Practice is limited to confines of the hospital and services under the supervision of the attending medical staff.

Temporary Licensing For Noncitizens Employed By State Hospitals

4731.292 — Provides for the issuance of a limited certificate to noncitizens of the U. S. for the practice of medicine or osteopathic medicine and surgery in state hospitals.

Applicant shall furnish proof that: (A) He has filed for naturalization; (B) Has passed the "educational council for foreign medical graduates" test; (C) Is 21 years old and of good moral character; (D) Is a graduate of reputable school in good standing; (E) Will limit practice to confines of the institution; (F) The institution has approved him; (G) He will practice only under attending staff; (H) He has made application to take State Board examinations.

License is valid for one year but may be renewed up to four times.

Applicant must take board examinations at first reasonable time.

Midwives

4731.30 — Midwifery — Applicant must be a

graduate of a college for nurse midwives in good standing as defined by the board.

4731.31 — The board shall give the examination for midwives.

4731.33 — The midwife must practice under the supervision of a physician.

Injunction Procedure for Illegal Practice

4731.341 — The practice of medicine in all its branches without a license is declared to be a public nuisance.

The attorney general, prosecuting attorney, or the state medical board, after January 1, 1969, may maintain an action for an injunction against unlawful practice.

Prior to injunction the medical board must notify by mail the person allegedly engaged in unlicensed practice that it has received information indicating that the person is so engaged.

If no reply is received within thirty days showing that he is either properly licensed or that he is not in violation, action may be brought.

The court will hold a hearing before issuance of an injunction.

Violation of injunction may result in penalties for contempt of court.

New Penalties

4731.99 — (A) Practice of medicine or surgery without a license: for first offense, \$50 - \$500 or 30 days to one year imprisonment, or both; subsequent, \$100 - \$500 or one year to three years imprisonment, or both.

(B) Midwifery without a certificate: for first offense \$50 - \$200; subsequent, \$100 - \$500 or 30 days to one year, or both.

(C) Osteopathy without certificate: for first offense, \$50 - \$500 or 30 days to one year, or both; subsequent, \$100 - \$500 or one year to three years, or both.

(D) False affidavit or false diploma — no change.

(E) Issuance false medical diploma — no change.

(F) False certification of disability — was \$50; now \$500.

(G) Unlawful prescription of intoxicating liquor — no change.

(H) Unlicensed practice of podiatry: for first offense, \$50 - \$500 or 30 days to one year imprisonment, or both; subsequent, \$100 - \$500 or one year to three years imprisonment.

(I) Unlicensed practice of Physical Therapy: first offense, \$50 - \$500 or 30 days to one year imprisonment, or both; subsequent, \$100 - \$500 or one year to three years imprisonment.

Fort Steuben Academy

The Fort Steuben Academy of Medicine had as guest speaker on October 10, Dr. F. Mason Sones, Jr., of Cleveland, who spoke on the subject, "Study of the Coronary Arteries by Dye Injection (Cine Angiography)." The dinner meeting was held at the Fort Steuben Hotel in Steubenville.

Dr. William D. Holden, the *Oliver H. Payne Professor of Surgery*, Case Western Reserve University School of Medicine, has been elected chairman of the American Board of Surgery.



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Outstanding Scientific Exhibits At OSMA Annual Meeting

ONE OF THE FEATURES at the 1967 OSMA Annual Meeting in Columbus, May 15-19 was the Scientific Exhibit and its companion Health Education Exhibit. From the many Scientific Exhibits on display the judging committee selected certain ones as outstanding. This procedure was in keeping with a recommendation of the Committee on Scientific Work approved by The Council. The authorized award in each case consists of a certificate of recognition, a permanent type plaque, and, in the case of the gold, silver, and bronze awards in the two fields of teaching and original investigation, monetary gifts. A summary of exhibits selected to receive awards was printed in the July issue of *The Journal*, with four additional exhibits designated for honorable mention. Following are brief descriptions of additional outstanding exhibits. Write-ups on other outstanding exhibits will be published in forthcoming issues of *The Journal*.

Renal Transplantation Exhibits Are Gold Award Winners

Two companion exhibits shared honors as Gold Award winners in the teaching field at the 1967 OSMA Annual Meeting. Sponsors of both received Gold Award mounted plaques and certificates, and shared the monetary gift.

Renal Transplantation

The exhibit, "Renal Transplantation," was sponsored by Drs. Donald G. Vidt, Bruce H. Stewart, and Satoru Nakamoto, of the Cleveland Clinic Foundation.

Following is a brief description of the exhibit and the material presented, adapted from information furnished *The Journal* by Dr. Vidt.

This exhibit reviewed the Cleveland Clinic experience with 152 renal transplants. Only patients with advanced, irreversible renal failure requiring dialysis were considered for ultimate transplantation. All patients were maintained on twice weekly hemodialysis, all had bilateral nephrectomies performed prior to transplantation, and approximately one-half of the patients in the series had had splenectomies and thymectomies performed prior to renal transplantation. Other factors in medical and surgical preparation of the recipients for transplantation have been reviewed.

A series of color drawings were used to illustrate the operative sequence in placing the donor homograft into the recipient. Special emphasis was placed upon presentation of the recipients for cadaver transplantation, since approximately 75 per cent of the Cleveland Clinic's experience had been with nonliving donors. The recipients are selected upon the basis of major blood groups when a potential nonliving donor kidney becomes available. To date 109 patients received cadaver kidneys from healthy, living relatives. The related donors are selected on the basis

of extensive lymphocyte typing procedures, which is in addition to the basic requirement that the major blood group be compatible.

Post-transplant management was reviewed, and the major complications of organ transplantation were listed. All patients received corticosteroids and azathioprine following transplantation. Recently developed antilymphocytic globulin was used in selected patients. In addition, Actinomycin-C and local irradiation of the homograft was used to combat rejection. The major complication following transplantation has been rejection. Other complications such as infection, vascular occlusion, urinary leakage, hemorrhage, ureteral obstruction, hepatitis, drug toxicity, and thrombophlebitis have been encountered. Certain diagnostic aids such as intravenous pyelography, radioactive renal scans, and renograms plus selective renal angiography have been of particular benefit in the early diagnosis of rejection as well as the early recognition of other complications.

The results of transplantation were summarized showing that 18 of 43 patients having received transplants from living donors are alive with functioning kidneys. Thirty-one of the 109 transplants from nonliving donors are alive with functioning kidneys at the time of presentation. A total of 22 patients received second transplants following failure of the first homograft with a resultant improvement in total patient survival. If the two year survival statistics of all transplants performed prior to June 30, 1965, are reviewed, it will be seen that 37 per cent of all patients receiving kidneys from living donors and 24 per cent of all transplants from cadaver donors remain alive with functioning kidneys as of the time of this report.

On the basis of experience to date, the sponsors conclude that (1) renal homotransplantation is technically and logistically possible, (2) renal homotransplanta-



This exhibit on "Renal Homotransplantation" is one of two companion displays which jointly won the Gold Award in the Teaching Field at the 1967 OSMA Annual Meeting in Columbus. Shown on the left accepting the Gold Award plaque is Dr. Bruce H. Stewart, one of the sponsors. Dr. Lawrence C. Meredith, 1966-1967 OSMA President is making the presentation.

The companion exhibit was entitled "Pathology of Renal Transplantation in Man." See accompanying article for details on both exhibits presented by teams from the Cleveland Clinic Foundation.

tion can provide prolonged survival with normal renal function and complete rehabilitation for selected patients, (3) improvement in surgical techniques, methods of donor selection, and immunosuppressive agents will result in better and longer survival, and (4) better methods of organ recovery and procurement, especially from nonliving donors will increase the availability of organs for renal homotransplantation.

Pathology of Renal Transplantation in Man

The exhibit, "Pathology of Renal Transplantation in Man," was sponsored by Drs. Sharad D. Deodhar, Kenneth Tung, Arthur E. Robertson, Satoru Nakamoto, and Ralph A. Straffon, of the Cleveland Clinic Foundation.

The following write-up giving background, nature of the material used in the exhibit, and certain conclusions derived from the material studied was furnished to *The Journal* by Dr. Deodhar.

Because clinical renal transplantation is still restricted to a handful of medical centers in the world, the pathology of human renal transplantation is not widely known. Over the past three years, some 135 renal homografts have been performed at the Cleveland Clinic. This provided a unique opportunity for the study of transplantation pathology in a large number of surgical and autopsy tissue specimens.

Through these studies, it was possible to characterize, by light, immunofluorescent and electron microscopy, the pathologic changes in the acute and late stages of renal graft rejection, and further investigate the role of cellular and humoral antibodies in this phenomenon. As evidence of the cellular mechanism of rejection, antibody carrying cells have been demonstrated—for the first time in man—in close proximity to the endothelial lining of small blood vessels of the transplanted kidney. The role of the humoral antibody was shown—again for the first time in man—by demonstrating the presence of im-

munoglobulins in the wall of small renal arteries by immunofluorescent technique. It is felt that this initial vascular injury, mediated by the cellular and humoral immune mechanisms eventually leads to the acute and chronic picture of the rejection reaction.

As a matter of added interest, the team was also able to study the pathology of certain complications that are frequently seen in the transplantation cases. These include such rare infectious disorders as cytomegalic inclusion disease, toxoplasmosis, histoplasmosis, other fungal and bacterial infections, me-

tabolic disorders such as systemic oxalosis and certain liver and neurological diseases.

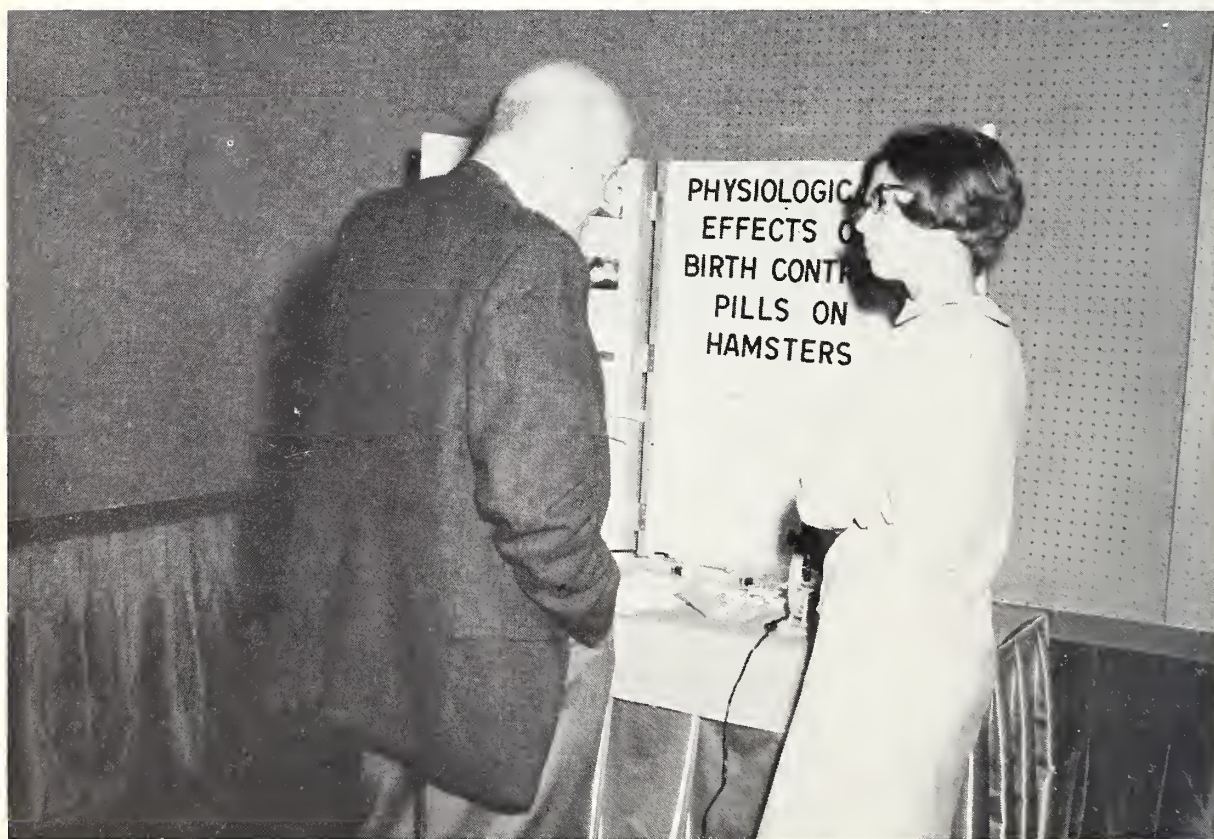
The significant results of these studies were illustrated in the exhibit. The exhibit itself was divided into four parts —

1. Illustrating the current, basic immunologic concepts in graft rejection reaction;

- 2 and 3. Illustrating the pathologic changes in the acute and chronic stages of graft rejection; and

4. Illustrating the pathologic complications frequently seen in patients with transplantation.

Student Exhibit Awarded Certificate of Merit



The high school student presentation shown above was a special feature in the Scientific Exhibit at the 1967 OSMA Annual Meeting, and was placed on recommendation of judges for the Educational Foundation of the Academy of Medicine of Columbus and Franklin County, after it won top honors at the Sixth Annual Central Ohio Regional Science Fair. The exhibit entitled "Physiological Effects of Birth Control Pills on Hamsters," was awarded a Certificate of Merit by the OSMA judging team. It portrays investigation on the part of Pamela Jo Phillips, of Whetstone High School, Columbus, who is shown

discussing her research project with Dr. Stephen E. Simay, of Jackson. Pamela is the daughter of Dr. and Mrs. Merle L. Phillips, of Columbus. Information on another student exhibit was published in the August issue of *The Journal*, beginning on page 1090.

Grants and fellowships totaling nearly \$1.5 million have been awarded this year by the Life Insurance Medical Research Fund. The Fund, which is supported by 138 life insurance companies in the United States and Canada, has distributed nearly \$22 million since it was organized in 1945.

Custodial Versus Skilled Service In Medicare Utilization Review

By HUGH F. HUGHES, Medicare Manager for Ohio
Nationwide Mutual Insurance Company

AS A PART A intermediary for many Ohio providers of health care, we feel we can be helpful by explaining the emerging concept of utilization review as it relates to Medicare and the involvement of physicians. Nationwide believes the intent of the legislation is to keep all utilization review decisions within the control of physicians because of the acute professional judgment required in rendering such decisions. Because of the many crucial decisions facing members of utilization review committees, the following remarks are offered in the interest of a better understanding of the problem by involved physicians.

The primary control in the Medicare Program is the utilization review mechanism. The function of utilization review is to distinguish between the patient's need for skilled medical services, which is covered under Part A, and custodial care, which is excluded from coverage. The role of the physician serving on a utilization review committee in a hospital or extended care facility setting is to make a determination as to the medical necessity for skilled services versus custodial care for individual patients. The intermediary's medical staff's determination as to whether the patient receives or continues to receive Medicare benefits for hospital or extended care facility confinement is based on their concurrence with the medical decision of the utilization review committee.

Custodial Care

Medicare regulations define custodial care as that type of care which is designed essentially to assist an individual in meeting his activities of daily living; i. e., services which consist of personal care such as help in walking and getting in and out of bed, assistance in bathing, dressing, feeding, and using the toilet, preparation of special diets and supervision of medication which can usually be self-administered — and which do not entail or require the continuing attention of trained medical or paramedical personnel.

There are two basic facts which must be noted in connection with this definition. First, the definition of custodial care does not contemplate an inter-

mediate level of care between covered (skilled services) care and custodial care. Accordingly, a decision that a patient is not receiving custodial care is also a decision that skilled service is being provided. Second, a decision that a patient lacks rehabilitation potential would not automatically result in a finding that the care furnished such a patient constitutes custodial care.

Many people who have no potential for rehabilitation require a level of care which is covered under Medicare. For example, a terminal cancer patient whose life expectancy is not more than a few months and who requires palliative treatment, periodic "tapping" to relieve fluid accumulation, and careful skin care and hygiene to minimize discomfort would not be considered as receiving custodial care.

Skilled Service

Generally, the care furnished a patient requires the continuing attention of trained medical or paramedical personnel if: (a) the patient's condition is such as to medically warrant the provision of "skilled service" and, (b) the need for such service constitutes the primary purpose of the total care furnished the patient.

According to Medicare regulations, a "skilled service" is defined as one which must be furnished by or under the supervision of trained medical or paramedical personnel if the health need of the patient is to be assured and the medically desired result is to be achieved. A service would not be classified as a skilled service merely because it is performed by a trained medical or paramedical person.

If a service is such that it can be safely and adequately performed (or self-administered) by the average, rational, nonmedical person, without the direct supervision of trained medical or paramedical personnel, it must be regarded as a non-skilled service without regard to who actually provides the service. For example, following the instructions given him, a person can normally take oral medicine prescribed by his physician. Consequently, the giving of such medication by a nurse when the

patient is unable to perform the service for himself because he is suffering from senility would not change the nature of the services from nonskilled to skilled professional services.

Similarly, the fact that extended care facilities are required to have all medications administered by licensed medical or nursing personnel in accordance with the Medical and Nurse Practice Acts of each State does not result in the administration of medications being classified as a skilled service in all instances.

Primary Purpose of Care Furnished

Before a determination can be made as to what is the primary purpose of the total care furnished a patient, it must first be determined whether all or any part of the skilled services are not reasonable or medically necessary to the treatment of the individual's illness or injury. Should it be determined that some part of the skilled services furnished are not a reasonable or necessary part of the patient's care and treatment, such services should not be included in considering what constitutes the primary purpose of the total care furnished the patient.

If a patient's condition is such that it is medically necessary to have the services of a nurse available to him at all times, the need for this service alone would be sufficient to justify a finding that the primary purpose of the total care is the provision of this skilled service.

In the absence of a need for continuing professional nursing services, the provision of skilled services to inpatients of hospitals and extended care facilities by paramedical personnel (other than nurses) would ordinarily not justify a finding that such paramedical services are the primary purpose for the total care furnished a patient. Therefore, in most instances, a determination as to whether the primary purpose of the total care furnished a patient is to assist him in meeting the activities of daily living or the provision of skilled services will turn on whether the patient's condition is such that it requires that the services of a nurse be available to him at all times.

For example, pending stabilization of his condition, the only skilled services a patient suffering from arteriosclerotic heart disease may require is continuing close observation by a trained nurse for signs of decompensation, loss of fluid balance, and the need for adjustment in digitalis dosage. However, since the immediate institution of necessary medical procedures would make the difference between life and death for such a patient where signs of decompensation are noted, such observation by trained personnel is absolutely essential to the patient's well-being. Under such circumstances, the primary purpose of the total care provided this patient would be the furnishing of the skilled service.

In those cases where a patient's need for the services of a nurse are only minimal, a determination that the

Medicare Benefits for the Expired Patient

A number of physicians have inquired how Medicare benefits can be paid for patient treatment when the patient expires before the physician's bill for services is paid.

Where the bill is paid by the patient's estate (administrator) or by a close relative or friend, arrangement can be made with the Carrier for the estate or individual paying the bill to receive applicable Medicare benefits. The person paying the bill submits a Request for Payment — SSA-1490 — form to the Part B Carrier.

In those cases where no one will assume responsibility for paying the physician's bill, the physician may collect Medicare benefits only by filing a Request for Payment — SSA-1490 — form with the Part B Carrier.

In such cases, the physician needs to accept an assignment of benefits in order to receive any payment for services rendered.

If the patient is a public assistance recipient, a patient signature is not requested in Part I of the SSA-1490 form; in other cases, the physician should explain on the form that there is no responsible person to sign for the patient. In most cases, the patient's file of a previous treatment will serve to substantiate evidence of services provided.

In some instances, the carrier may find it necessary to obtain additional information from the physician in order to determine what Medicare benefits may be paid.

furnishing of skilled services is the primary purpose of the total care furnished the patient would be justified only if it is found that the range and intensity of all the skilled services furnished are such that it would not be feasible, in view of the patient's condition, to have them provided outside the institutional setting. It is anticipated that such situations will probably be limited to those where a patient is hospitalized for extensive diagnostic tests.

It should be recognized that even when a determination of custodial care is reached, it is, of course, possible that only a portion of the stay in the institution has been custodial. Therefore, in such cases, a second determination will usually have to be made as to when the care received by the patient became primarily custodial in nature.

ACCREDITATION NOTES . . .

A Question-and-Answer Column Conducted in Collaboration with
The Joint Commission on Accreditation of Hospitals
John D. Porterfield III, M. D., Director



Q. How does the Joint Commission evaluate the subjective differences that various examiners have in their examination techniques and personal practice interests on a survey? Occasionally this factor leads to conflicting recommendations or over-emphasis in an area not so considered by another examiner.

A. The JCAH devotes time and effort to this point. For some years now it has used full-time physician surveyors in the effort to develop training and experience in the accreditation process and the overall point of view. The orientation period for new field representatives has been lengthened and improved as has the annual workshop for field staff. The chief of the program now sends each of them, wherever they are, a weekly newsletter, discussing policy interpretations and procedure techniques. All survey reports are reviewed by one central office medical staff where any excessive personal variations are noticed and ironed out. The individual background and flavor still exists to some degree and this is not bad if not too conflicting for the policy of JCAH provides that the same surveyor does not do successive surveys at the same hospital. In that way, over several surveys, a hospital gets a more rounded consultation and critique. There is now a standing committee of the Board of Commissioners studying the survey procedures intensively and more improvements will be introduced as they are identified. Any major conflicts in successive recommendations should be the subject of correspondence with JCAH and usually is.

Q. What recourse does the hospital have in the appealing what appear to be unfair or discriminatory findings on the part of an examiner?

A. The by-laws of JCAH provide that a hospital which has been refused accreditation may appeal to the Board of Commissioners and be granted a hearing by a committee of Commissioners. This committee may recommend a reversal of decision to the Board if

the hearing brings out evidence that the survey report did not correctly portray conditions. It has happened. Aside from the accreditation decision, remember the standards are developed by a voluntary professional body and constitute the best opinion which experienced consideration can devise. The consultation report is explanatory and advisory for the thoughtful consideration of the medical staff and the governing body. If it appears to be unfair and discriminatory, it is not intended. Say so and tell us why you think so. We benefit by consultation too.

Q. Has inclusion of the rules and regulations of the Joint Commission into the Federal Register enhanced or decreased the flexibility of these regulations?

A. The standards of the JCAH continue to remain fully within the discretion of the Board of Commissioners of JCAH, which will amend them whenever it is convinced a change is warranted by scientific evidence and professional experience. The publicity in the Federal Register was given to the Conditions for Hospital Certification for Participation in the Medicare Program, devised in part by Congress and in part by HEW. Federal law does provide that these Conditions may not exceed JCAH standards (unless a state statutory code is higher yet), but this reference does not immobilize JCAH thought, a voluntary operation of and by the profession.

Q. Why are laboratories in hospitals approved, just because the hospital has been accredited, when independent laboratories must have rigid inspection by the Department of Health?

A. Hospital laboratories are not approved independently by the JCAH. They are surveyed as part of the hospital, and accreditation when granted is for the entire hospital to which the laboratory survey has contributed. The requirement that independent laboratories have rigid health department inspections is not an action of JCAH. The section of the standards and survey procedure covering hospital laboratories as part of the hospital-accreditation process is just now under careful review by JCAH.

Questions from *The Journal's* readers may be directed to the Joint Commission on Accreditation of Hospitals, John D. Porterfield III, M. D., Director, 645 N. Michigan Avenue, Chicago, Illinois 60611, or to *The Journal* for referral to Dr. Porterfield and his staff.

Ohio State Medical Association

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October 18, 1967

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Dear Doctor:

The Ohio State Medical Association and its Delegation to the American Medical Association are pleased to announce the candidacy of Carl A. Lincke, M.D., a dedicated member of the AMA House of Delegates since 1946, for the office of Vice President of the American Medical Association. The Ohio Delegation will nominate Dr. Lincke for this important office at the 1968 Annual Convention in San Francisco.

A privately practicing physician in Carrollton, Ohio, Dr. Lincke has a long and brilliant record of outstanding service to the medical profession and to his community. He has served as president of the Carroll County Medical Society, as a member of the Ohio State Medical Association's House of Delegates, as a member of the OSMA Council and as president of his State Association. He was the youngest physician ever elected to the presidency of the Ohio State Medical Association.

In addition to his 21 years of judicious and attentive service as a member of the AMA House of Delegates, Dr. Lincke served as a member and chairman of the AMA Council on Scientific Assembly.

Dr. Lincke is highly respected by members of his profession on the local, state and national levels. He is deliberate in judgment, resolute, forthright and open-minded. His dedication and service to our profession make him eminently qualified for the office of Vice President of the American Medical Association.

Your support of Dr. Lincke's candidacy is earnestly solicited.

Sincerely,

Robert E. Howard
Robert E. Howard, M.D., President
Ohio State Medical Association

John H. Budd
John H. Budd, M.D., Chairman
The Ohio Delegation

REH/dw

Ohio Announces the Candidacy of Carl A. Lincke, M. D.

for Vice-President of the American Medical Association

THE COUNCIL of the Ohio State Medical Association, at its September meeting unanimously endorsed the candidacy of Carl A. Lincke, M. D., for the office of Vice-President of the American Medical Association. This action was taken in full accord with similar endorsement by Ohio's Delegation to the AMA, which met concurrently with The Council.

Dr. Lincke is well-known in professional circles and among medical organization workers both in Ohio and elsewhere. He is a general practitioner in Carroll County, a Past President of the Carroll County Medical Society, former Councilor of the Seventh District and Past President of the Ohio State Medical Association, and an Ohio Delegate to the AMA.

Following is a summary of other accomplishments, activities, and honors, a record which speaks for itself.

A native of northeastern Ohio, Dr. Lincke was born in Alliance, and received his elementary and high school education there. In 1927 he was graduated from Ohio State University with an A. B. degree, and in 1931 he received his medical degree from the OSU College of Medicine.

After completing a rotating internship at the former White Cross Hospital in Columbus, he entered practice in Carrollton in 1932, and has been

gates in 1948, one of the youngest men ever so honored by his colleagues in this state. His year in office as President was during the 1949-1950 period.

He was already a Delegate to the American Medical Association when he became State President, having been named to that office in 1946. He was one of the founders of Ohio Medical Indemnity and served on the OMI Board of Directors and the Executive Committee. As an AMA Delegate, he was named to numerous committees and councils including the Council on Scientific Assembly on which he served for 14 years (one year as chairman).

He has been a member of the Ohio and American Academies of General Practice since 1947; is a former president of the Ohio State Medical Alumni Association, and served as secretary-treasurer of the Ohio Medical Political Action Committee.

In community and civic affairs he has been equally active. He is president of the Cummings Bank Company, a member of the Carrollton Planning Commission, member of the Board of Public Affairs, medical adviser for the Carroll County Cancer Society; past president of the Carrollton Rotary Club and former District Governor for Rotary International; trustee of the Carroll County Historical Society.

In 1962 Dr. Lincke was honored at a "This Is Your Life" tribute sponsored by the local Chamber of Commerce, and attended by relatives and friends from Ohio and neighboring states.

Church and fraternal affiliations include the Presbyterian Church, in which he is an Elder; the Masonic Lodge and several advanced Masonic bodies including the Shrine; the Elks Lodge, and the Atwood Yacht Club.

Dr. Lincke is married to the former Marie Herron. The family includes a son, Carl Edward Lincke, a daughter, Ann Marie Saltzman, and three grandchildren.



Carl A. Lincke, M. D.

in the general practice of medicine there ever since. Among professional affiliations, he is a staff member at Aultman Hospital in Canton, and at Mercy and Timken Mercy Hospitals, in Canton.

Dr. Lincke was first elected to The Council of the Ohio State Medical Association in 1942, after serving as President of the Carroll County Medical Society the previous year. He was named President-Elect of the State Association by the House of Dele-

Stimulus for Medical Education...

Loan Guarantee Programs and Biomedical Research Emphasized As Ohioans Are Urged to Make Contributions to the AMA-ERF

OHIO'S ANNUAL CAMPAIGN in behalf of the American Medical Association Education and Research Foundation is now underway to make it possible for Medical Education Loan Guarantee Programs and Biomedical Research.

Dr. Robert S. Martin, Zanesville, is chairman of the Ohio AMA-ERF Committee, which is composed of the chairman and the 11 District Councilors of the Ohio State Medical Association.



Dr. Martin

\$1,350,000 in loans have been arranged by the American Medical Association Education and Research Foundation for Ohio medical students alone. This constitutes 1200 loans. Nationally, this program has provided \$44,000,000 to 19,000 students in loans. Every one dollar YOU give makes \$12.50 available for a medical student under the Loan Guarantee Program.

In 1966 AMA-ERF contributions from Ohio physicians dropped 34 per cent below 1965 and only one out of every twelve Ohio physicians gave to this pro-

gram. To date Ohio stands in a four-way tie for 22nd place among the 50 states in dollars given.

Dollars contributed under this program are also used for supporting the AMA Institute for Bio-



medical Research which is now in its third year and has a group of more than 30 outstanding scientists delving into basic life processes.

This Foundation is supported solely from contributions and operates without the use of any governmental funds.

Realizing the importance of keeping medical education independent through private initiative and voluntary effort, Dr. Martin, members of the 1967 Ohio AMA-ERF Committee, and the local chairmen urge Ohio physicians to respond generously in this year's campaign.

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Ad Astra

Walter Dumas Anderson, M. D., Yuma, Arizona; Western Reserve University School of Medicine, 1950; aged 47; died May 12. Records indicate that Dr. Anderson left Ohio after completing his medical training and practice for several years in Des Moines, Iowa.

Howard Wesley Bangs, M. D., Akron; State University of New York Upstate Medical Center, 1945; aged 48; died September 18; member of the Ohio State Medical Association, the American Medical Association, American Radiological Society of North America; Fellow of the American College of Radiology; diplomate of the American Board of Radiology. A resident of Akron for 12 years, Dr. Bangs was radiologist for the St. Thomas Hospital. Among survivors are his widow, two sons, and two daughters.

Wilbur Graham Fisher, M. D., Columbus; Washington University School of Medicine, St. Louis, 1935; aged 62; died September 8; former member of the Ohio State Medical Association. A general practitioner in Columbus for many years, Dr. Fisher was formerly associated with the tuberculosis sanatorium in Mt. Vernon. Surviving are a sister and two brothers.

S. Oscar Fry, M. D., Charles Town, West Virginia; University of Cincinnati College of Medicine, 1923; aged 69; died May 23. Records indicate that Dr. Fry moved to New York after completing his medical training in Ohio, and later moved to West Virginia.

Delmar Ray Gard, M. D., Alliance; Vanderbilt University School of Medicine, 1937; aged 56; died September 9; former member of the Ohio State Medical Association and the American Medical Association. A resident of Alliance for 22 years, Dr. Gard practiced in the field of pediatrics and was city health commissioner. A native of League City, Texas, he practiced for a while in Massillon and was a veteran of World War II. Survivors include his widow, two sons, a daughter, his father, a brother, and a sister.

Clifford Newell Heisel, M. D., Covington, Ky.; University of Cincinnati College of Medicine, 1912; aged 77; died May 27. A practitioner of long standing in the Covington area, Dr. Heisel had professional associations in Cincinnati.

Horace Marshall Korns, M. D., Iowa City, Iowa; Western Reserve University School of Medicine, 1918;

aged 74; died April 18; former member of the Ohio State Medical Association. Records indicate that Dr. Korns practiced in the Cleveland area until the late 1920's when he moved to Iowa.

Howard Noel Kuhn, M. D., Bellevue; Ohio State University College of Medicine, 1937; aged 54; died September 6; member of the Ohio State Medical Association and the American Medical Association. An earlier resident of Bellevue, Dr. Kuhn returned there to practice in 1938. During World War II he served in the Navy and attained the rank of lieutenant commander. Affiliations included memberships in the American Legion, the VFW, the Masonic Lodge, and the United Church of Christ. Surviving are his widow, a daughter, three sons, and a sister.

Joseph E. McNalley, M. D., Canton; University of Kansas School of Medicine, 1924; aged 75; died September 22; member of the Ohio State Medical Association and the American Medical Association. Dr. McNalley was a native of Michigan Valley, Kansas and a resident and practitioner in Canton for some 37 years. He was a veteran of World War I. Dr. James A. McNalley, also of Canton, is one of two brothers who survive.

John Steven Meyers, M. D., Versailles; St. Louis University School of Medicine, 1933; aged 58; died September 19; member of the Ohio State Medical Association, the American Medical Association, and the American Academy of General Practice. A native of Versailles, Dr. Meyers practiced in the area for 34 years. He was active in the affairs of the Darke County Medical Society and twice served as its president. He was a trustee of Wayne Hospital, Greenville, a veteran of World War II, member of the American Legion, VFW, the Catholic Church, and the Knights of Columbus. Surviving are his widow, three daughters, and two sisters.

Oliver Frederick Miller, Jr., M. D., Bloomsburg, Pa.; Western Reserve University School of Medicine, 1935. Records indicate that Dr. Miller left Ohio after completing his medical training.

James Van Dyke Nelson, M. D., Miami Springs, Fla.; Medical College of Ohio, Cincinnati, 1904; aged 88; died April 23. Dr. Nelson was living in retirement after a long medical career.

Gordon Allen Pilmer, M. D., San Angelo, Texas; Ohio State University College of Medicine, 1940;

(Continued on Page 1529)

(Continued from Page 1524)

aged 53; died September 19. Records indicate that Dr. Pilmer left Ohio early in his career to practice in the southwest. He is survived by his widow, three sons, a daughter, his mother, and a sister.

Thomas LeRoy Ramsey, Sr., M. D., Toledo; Medical College of Ohio, Cincinnati, 1909; aged 82; died September 12; member of the Ohio State Medical Association and the American Medical Association; diplomate of the American Board of Pathology. A resident of Toledo for some 45 years, Dr. Ramsey specialized in pathology and for many years was associated with St. Vincent Hospital. He was a veteran of World War I, a member of the American Legion, and the Masonic Lodge. He is survived by his widow, a daughter, and a son.

William Karl Romoser, M. D., Columbus; Ohio State University College of Medicine, 1935; aged 58; died September 20; member of the Ohio State Medical Association and the American Medical Association. A practicing physician of long standing in Columbus, Dr. Romoser was a veteran of World War II. Survivors include his widow, a son, and a sister.

Lawrence P. Schumake, Jr., M. D., Cleveland; Meharry Medical College, 1938; aged 55; died September 2; member of the Ohio State Medical Association, the American Medical Association, and the American Academy of General Practice. A former resident of Cleveland, Dr. Schumake returned there to practice after World War II. During the war he served with the Army Medical Corps overseas and attained the rank of lieutenant colonel. Among professional activities he was on the board of trustees and former chief of staff at Forest City Hospital. Survivors include his widow, four sons, and his parents.

William Philip Smith, Sr., M. D., Columbus; Ohio State University College of Medicine, 1918; aged 79; died September 26; member of the Ohio State Medical Association; Fellow of the American College of Surgeons and the American Society of Abdominal Surgeons. A surgeon and gynecologist in Columbus of long standing, Dr. Smith traveled extensively in connection with his professional work and lectured often abroad. For many years he was associated with the faculty at Ohio State University College of Medicine. Among affiliations, he was a member of the Methodist Church, and several Masonic bodies. Dr. William P. Smith, Jr., of Columbus, is his son. Also surviving are his widow, two daughters, a brother, and a sister.

Clyde Kenneth Walter, M. D., Canfield; Western Reserve University School of Medicine, 1941; aged 53; died September 24; member of the Ohio State Medical Association, the American Medical Association, American Academy of General Practice, and the

American College of Allergists. Dr. Walter practiced medicine in the Canfield area for 21 years, and among local activities was a member and former president of the Canfield board of education. Survivors include his widow, two sons, and two brothers.

John Henry Warvel, Sr., M. D., Indianapolis; Ohio State University College of Medicine, 1916; aged 73; died June 19. Records indicate that Dr. Warvel left Ohio shortly after completing his medical training to practice in Indiana.

Alfred Matthew Wedd, Rochester, N. Y.; Western Reserve University School of Medicine, 1916; aged 79; died May 12. Records indicate that Dr. Wedd left Ohio after completing his medical training and practiced in the eastern states.

Ohio Medical Executives Hold Workshop in Youngstown

Robert E. Howard, M. D., OSMA President, was the keynote speaker at the second annual workshop conference of the Association of County Medical Executives (ACME) held at Youngstown, October 5-6. He spoke on the topic, "What Do Physicians Expect of Their County Society Executives?"

Highlights of the two-day program included a presentation on business methods by Sidney Mountcastle, Akron; a discussion panel on P. L. 89-239 Regional Medical Programs, consisting of Edward F. Willenborg, Cincinnati; Bill Webb, Columbus; Robert A. Lang, Cleveland; and Robert W. Elwell, Toledo; with Don Mortimer, Cleveland, as moderator; and a discussion of Title XIX by Ed Willenborg with Howard Rempes, Youngstown, as moderator.

John H. Austin, Canton, moderated a discussion of individual problems presented by Mrs. Gladys Davidson, Lorain; Mrs. Patsy Jo Askins, Sandusky; Mrs. David Wolfert, Erie; and Mrs. Kay Ticknor, Trumbull County.

Twenty medical executives attended the meeting. In addition to those already named, participants were: Edward W. Hoffman and Parker H. Moore, of Cincinnati; Miss Jean Armour, of Columbus; Mrs. Ella Tidd, Youngstown; Earl E. Shelton and Mrs. Willadean Mitchell, Dayton; Dana Whipple, Medina; and Alex Lagusch, Cleveland.

The Association was welcomed to Youngstown by Harold J. Reese, M. D., president, Mahoning County Medical Society. Ed Willenborg, president of ACME, presided at the business meeting. Meeting arrangements were made by Howard Rempes, assisted by Mrs. Gladys Davidson and Bob Lang.

The Southwestern Ohio Society of Family Physicians presented a seminar on "Correctable Skeletal Diseases of Children" at the College of Medicine auditorium on September 24. For the October 8 seminar, the topic was "Skeletal Problems of the Adult."

Columbus Physician Is Honored With Testimonial Dinner

Dr. Jonathan Forman, physician of long standing in Columbus, former Editor of *The Ohio State Medical Journal*, educator, author, and lecturer, was honored at a testimonial dinner on September 30, the occasion of his 80th birthday.

The celebration was sponsored by "Friends of Dr. Forman," a group of more than 50 persons prominent in Ohio and in other states. The name is reminiscent of "Friends of the Land," a conservation organization long promoted by Dr. Forman as one of his chief interests.

Some 300 persons attended the reception and dinner in the Sheraton-Columbus Hotel in downtown Columbus to honor Dr. Forman and to extend greetings to him, Mrs. Forman, and several members of the family who were present.

Dr. N. M. Newport, practicing associate of Dr. Forman in the allergy field, introduced the toastmaster for the occasion, Harold Yochum, D. D., President of Capital University. Featured speaker was Chauncey Leake, Ph. D., professor of pharmacology, University of California, who used as his topic, "Jonathan Forman and Ever Better Medical Practice."

Among honors bestowed during the evening was a citation from Sigma Delta Chi, professional journalism fraternity, for his contributions to the writing field, a citation from the hundred thousand mile airliner club for his having passed the million mile mark in air travel, and a personal appearance of Columbus Mayor Maynard Sensenbrenner, who praised Dr. Forman as an outstanding citizen of the community.

A bound volume of testimonial letters written by well-wishers was presented by Mrs. Helen Marsh, secretary to Dr. Forman, and secretary also of the sponsoring organization. Another tribute was a printed pamphlet entitled "Jonathan Forman, A Biographical Sketch and His Curriculum Vitae," compiled and written by Mrs. Marsh, a copy of which was presented to each person present.

The Cleveland Clinic Foundation Offers Postgraduate Courses

The Cleveland Clinic Educational Foundation, 2020 East 93rd Street, Cleveland 44106, has announced a number of postgraduate programs for the 1967-1968 season, among which are the following:

Problems in Pelvic Surgery — November 8 and 9.
Pain: Neurological and Neurosurgical Aspects—
November 15 and 16.

Postgraduate Course in Ophthalmology — December 6 and 7.

Treatment of Surgical Emergencies — January 17 and 18.

General Practice — January 31 and February 1.

Recent Advances in Pediatrics — February 28 and 29.

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Activities of County Societies ...

CUYAHOGA

The Academy of Medicine of Cleveland and the Cleveland Mental Health Association are among sponsors of a center to be known as the Psychiatric Emergency Evaluation and Referral Service, scheduled to open soon in the Carnegie Medical Building in Cleveland.

A 24-hour service is scheduled to give attention to potential suicide victims and other persons with immediate mental health problems. Director is Dr. June Rees, former staff member at the Fairhill Psychiatric Hospital. Resident physicians at University Hospitals will be on call in emergency cases.

At last report, funds had been raised from various donations for most of the first year's operating expenses of the program scheduled for a two-year trial period.

The second medical conference sponsored jointly by the Academy and John Carroll University was held on September 13 at the university campus. Invited to the conference were physician members, wives and guests, university personnel, hospital administrators, and Cleveland civic leaders. Theme of the program was "The Physician and His Hospital."

In addition to Academy meeting, *Cleveland Physician*, official bulletin of the Academy, listed numerous monthly meetings of the specialty organizations in the Cleveland area.

FAIRFIELD

The Twentieth Anniversary of the founding of the Woman's Auxiliary to the Fairfield County Medical Society was celebrated at a joint dinner meeting of the Auxiliary and the Society, October 10th, at the Lancaster Country Club. Over 60 physicians and wives of physicians enjoyed the occasion.

George H. Saville, retired Executive Secretary of the Ohio State Medical Association, related the story of the founding of the Woman's Auxiliary to the Ohio State Medical Association at Cincinnati, May 15, 1940. The speaker was the first Secretary of the organization. Upon his retirement, he was named Honorary Secretary of the Auxiliary in recognition of his services to organized medicine for over 30 years.

Robert L. Rupp, C. L. U., Columbus, discussed estate planning and the provisions of the revised Keogh plan to provide retirement benefits for physicians, at the same time effecting substantial income tax benefits. He showed an explanatory film, in color, entitled "Give Yourself A Break."

HAMILTON

The annual meeting of the Academy of Medicine of Cincinnati was held on September 19, at which time new officers were installed. As outgoing president, Dr. Elmer R. Maurer addressed the Academy, and Dr. Stanley D. Simon was installed as president for the coming year. In his inaugural address, Dr. Simon spoke on the topic, "The Academy of Medicine — the Doctors' Forum."

A number of Cincinnati area Specialty Societies began a series of meetings for the 1967-1968 season in late September and early October. Topics, meeting dates, and speakers for these special meetings are customarily published in the *Cincinnati Journal of Medicine*.

KNOX

"Give Yourself A Break," a color film explaining new provisions of the Keogh pension plan, effective January 1, 1968, was shown by Robert L. Rupp, C. L. U., Columbus, in his presentation at a dinner meeting of the Knox County Medical Society, October 4, at The Alcove Restaurant, Mt. Vernon. Mr. Rupp told approximately 20 physicians present how they could provide for their retirement, at the same time obtaining increased deduction for income tax purposes. He also discussed estate planning.

LICKING

Robert L. Rupp, C. L. U., Columbus, was guest speaker at a meeting of the Licking County Medical Society on September 26 at the Moundbuilders' Country Club, Newark. He discussed amendments to the Keogh pension plan law, and new provisions under which physicians can make additional income tax deductions for retirement programs effective in 1968. Mr. Rupp showed a color film entitled, "Give Yourself a Break." There were approximately 35 members present. A business meeting followed Mr. Rupp's presentation.

LORAIN

The regular meeting of Lorain County Medical Society was devoted to business affairs, when members met at the Americana Restaurant, Elyria, on October 10. President R. S. VanDervort reported on the balance of funds in hand after expenses of the Measles Clinics on May 21st had all been met. Council's recommendation that this amount — \$1,596.91 — be forwarded to the Lorain County Medical Foundation's scholarship fund received unanimous approval from the members. The Foundation

offers annual scholarships to students studying toward careers in medicine and other health related fields.

Announcement was made of the Nominating Committee for the slate of officers in 1968, and two new members, Richard Buchanan, M.D., of Elyria, and Maximo Oania, M.D., of Lorain, were elected to Associate Membership. The following physicians were elected to Active membership: M. A. Amiri (Lorain), George P. Gotsis (Lorain), Valentine C. Marr (Avon), Lawrence G. Thorley (Elyria) and Charles E. Zepp (Elyria).

During a question and answer period, discussion centered on problems encountered in the medical care of welfare clients and proposed family planning program in the county.

LUCAS

A joint program for physicians and the clergy was sponsored by the Medicine and Religion Committee of the Academy of Medicine of Toledo and Lucas County on October 11. Subject for discussion was "Suicide," and the film, "A Cry for Help" was shown as part of the program.

Among principals in the program discussion were Dr. William Easson, professor in the Department of Psychiatry, Toledo Medical College; and Father Francis Crawford, chairman, Rescue, Incorporated.

The Postgraduate Lecture Series sponsored by the Medical Advancement Trust of Maumee Valley Hospital was held on October 18 and 19. Guest lecturer was Dr. Donald S. Miller, professor of orthopaedics, Chicago Medical School, whose talks centered around various orthopaedic situations.

SUMMIT

John S. Millis, Ph. D., chancellor of Case Western Reserve University, author of the Millis report on medical education, spoke at the September 5 meeting of the Summit County Medical Society in Akron.

For the October 3 meeting at Children's Hospital, the speaker was Dr. Frank L. Leyman, director of industrial medicine for the Geigy Chemical Corporation, whose subject was "Medical Aspects of Pesticide Use."

Anesthesiologists Elect Officers at Recent 28th Annual Meeting

At the recent 28th annual meeting of the Ohio Society of Anesthesiologists, Inc., in Youngstown, Dr. Rudolph G. Schmidt, of Dayton, was installed as president to succeed Dr. Edward Hartenian, of Cincinnati.

Dr. Robert T. Brown, of Findlay, was named president-elect, and Dr. Steven Kovacs, of Cleveland, secretary-treasurer. Dr. DeForest W. Metcalf, of Youngstown, was chairman of the planning committee, and Dr. Nicholas G. DePiero, Cleveland, presented a message from the president of the American Society of Anesthesiologists.

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Woman's Auxiliary Highlights ...

By MRS. S. L. MELTZER, Chairman, Publicity Committee

2442 Dorman Drive, Portsmouth 45662

THERE is something incredibly rewarding about Fall Conference. The opportunity to meet so many representatives from counties all over the state is indeed a priceless one. There is an exchange of ideas, a wonderful sense of camaraderie, an aura of dedication and a down-to-earth chance to engage in those "bull sessions" that can be productive of so much good. This year's Fall Conference, September 28 and 29 at Canton should have provided local auxiliaries with an especially therapeutic shot in the arm! A salute to Mrs. Malachi W. Sloan, II, in charge of the Conference and her two cochairmen — Mrs. Charles Houck and Mrs. Clarence V. Smith.

There was fun too. (Can't have all work and no play!) The unbelievable "style show" following the Thursday night dinner told the story of safety in a provocative and hilarious fashion — masterminded by Mrs. C. Raymond Crawley. The costumes worn by the models were unique and to the point! President-Elect Mrs. Sloan did the commentary. The courageous models included: Mrs. Paul Sauvageot (Madame President), Mrs. Herbert Van Epps, Mrs. Carl Goll, Mrs. Calvin Warner, Mrs. Paul Hahn, Mrs. Carl Frye, Mrs. A. G. Steele, Mrs. Edward L. Doermann, Mrs. Duane E. Banks and Mrs. H. W. Allison. Mrs. A. H. Kyriakides was at the piano. (If I've omitted someone's name, it's because I got so carried away with the sterling performances, I almost forgot to take down any name! If I am guilty of overlooking any of these tremendous gals, my apologies!)

There was a "dramatic" performance at the end of the Friday morning sessions. This featured three members of the Lucas County auxiliary: Mrs. Max Schnitker (barrister's wig 'n all), Mrs. Daniel Wolff and Mrs. Howard Smith (both of whom made many amazing "changes" in their many different roles).

This too got a pertinent message across in hilarious fashion. If any local group would like to put on either the style show or the courtroom scene, I am confident that both Mrs. Crawley and Mrs. Smith would be glad to accommodate — with the "copy," that is! Mrs. Crawley can be reached at 1507 Seven Mile Drive, New Philadelphia; Mrs. Smith at 2144 Fordway, Toledo.

Before I leave Fall Conference talk, I must share with you a bit of verse from the pen of the delightful Mrs. Max Schnitker, International Health chairman. This reporter had quite a time getting permission from Enid to use her literary effort (which was given at her session on International Health). I'm sure you will agree with me that it packs a wallop of a message in an easy and charming fashion and is something any local group can use in promoting International Health. Here it is:

A chairman called Enid once said
Verbosity bothers my head;
My three-minute limit
Has much merit in it —
A long, drawn-out story is dead.

So first let me tell you of Hope
The hospital ship of such scope.
Next year to Ceylon you will find
She has gone;
Will you help with expenses to cope?

In Detroit dwells a lady with vision
The whole great wide world is her mission;
Collect drugs and care —
With the world's poor to share
Gifts, to us so abundantly given.

Vietnam is a word on a map —
Seems there we are caught in a trap.

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But let's help train their gals
To learn medical skills
Ho Chi Minh will then seem just a sap.

Foreign doctors who come here to stay
And learn our American way
Will welcome your smile
And, after a while,
More than medical knowledge have they.

My limerick's over and done
Please accept it as serious fun;
Nothing that you can do
Will do more good for you
(And there's many a truth in a pun!)

Around the State

Mrs. Reuben Gould, president of Cuyahoga County auxiliary, has sent me some interesting and refreshing copy that was prepared by the auxiliary for the November Bulletin of its County Medical Society. It is called "From The Back Seat." This November copy detailed, among other things, vital facts on air pollution . . . "today the spell of Indian Summer does not linger in the air." It pointed out that Cuyahoga County is one of five areas in the United States with the highest pollution count. "From The Back Seat" urged every doctor and doctor's wife to "make the study of air and water pollution your business — then get busy with your legislators . . ."

Mrs. John B. Hazard, a State Board member, came up with a terrific idea recently—a Barn Sale. She was dismantling her home, preparatory to moving into an apartment, and she suddenly realized that here was an opportunity for her Cuyahoga auxiliary to make some money. And it did—netting well over \$600! It was all handled on a percentage basis. There were many beautiful antiques from Mrs. Hazard's home; there were other choice items auxiliary members offered for sale; and there were many attractive "white elephants" that were snapped up fast. Along with the opportunity for the auxiliary to make money, it provided satisfied customers and

a lot of fun. A luncheon was provided for one dollar. The Barn Sale had all the fascination of an old-fashioned New England auction!

At Cuyahoga's September meeting, the guest speaker was Mrs. Francis Silver of Educational TV-WVIZ fame and an auxiliary member herself. A "happy hour" preceded the luncheon. Mrs. Silver spoke on the "Life and Times of Elsie Dinsmore," an especially entertaining presentation of that period when Martha Findley wrote her 26-volume "Elsie" series—1868-1909. Mrs. Silver correlated the books sociologically with the era. For you "young 'uns" who didn't have to grow up with Elsie, she was the perfect child who could do no wrong. I may not be echoing Mrs. Silver's sentiments on Elsie Dinsmore since I did not have the privilege of hearing her but most of the more ordinary little girls of that era hated the perfect Elsie with a passion!

Mrs. J. K. Lasser spoke on the "Reach to Recovery" program at Cleveland's Academy of Medicine on November 10. This type of program provides encouragement and rehabilitation for postoperative radical-mastectomy patients. Dr. P. John Robeck presided at the question and answer period. The meeting was open to the public.

Franklin County

The first meeting of the Fall season was held on September 18 by the Franklin County group at the Lindenhof in Columbus' famous German Village. (It's almost like stepping into another world when you visit this fascinating area in the state capital.) Following the luncheon and business meeting, the group toured the Franklin Glass Company. Mrs. Donal O'Leary, program chairman, and Mrs. Charles Mooers arranged the meeting, assisted by Mrs. Floyd Beman, social chairman. Mrs. Dale Dickens and Mrs. Merle Phillips served as hostesses.

The sale of Christmas cards for the benefit of AMA-ERF was announced at this meeting. Mrs. Charles Deishley, community service chairman, told of the auxiliary's assistance with the Senior Citizens'

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Hobby Show. Mrs. Addison Kefauver, International Health chairman, urged members to save all drug samples received by their husbands. Mrs. H. C. Bautista, mental health chairman, put out an SOS for the home-made cookies that are donated each month to the State Hospital. Mrs. Joseph Tomaszewski, chairman of Project Scholarship, revealed that there are now three girls participating in the program — the one at Riverside School of Nursing, the second at St. Francis School of Nursing and the third at Mt. Carmel School of Nursing.

Here's a fine idea for other auxiliaries to copy: Franklin County members are receiving, previous to each meeting, an informative, interesting and well-planned Newsletter that keeps them up-to-date on coming events and generally informed on all auxiliary projects. The Newsletter is edited by Mrs. Charles Rossel, publicity chairman, and has an attractive format. Franklin's 1967-68 slate of officers includes: Mrs. John Riepenhoff, president; Mrs. Carl E. Tetirick, president-elect; Mrs. William Krech, vice-president; Mrs. Leonard Greentree, recording secretary; Mrs. Frank Lyon, corresponding secretary; Mrs. Alfred Slivinski, treasurer; and Mrs. Charles Mooers, assistant treasurer.

Scioto County

October was a busy month for this Southern Ohio auxiliary. On October 11, there was a birthday luncheon at Harold's Restaurant (the group was celebrating its 27th birthday). The occasion also served as an opportunity for Mrs. Armin Melior, Ninth District director, to emphasize the need for more concerted activity in organizing other counties in that district. Nine members from Lawrence County attended. Mrs. Harry L. Fry, state vice-president, and Mrs. Calvin Warner, past state president and state finance chairman, addressed the group. Guest speaker was Dr. Jerome Sheets, president of the

Portsmouth School Board, who discussed the vital issue of the school levy. A feature of the afternoon was an exhibition of ceramics made by some of the doctors' wives and a talk and demonstration by Mrs. Ann Harwood who conducts a school on ceramics. Mrs. Clyde O. Hurst, Scioto County president, presided at this October meeting. Mrs. Robert Counts was luncheon chairman.

The group's Ways and Means Committee came up with something new on Thursday evening, October 18—a "Viene a la Fiesta Italiano" hosted by the doctors' wives for their doctor-husbands. The invitations were written in Italian on red-checked paper made to simulate a napkin. There was the 6:30 p.m. "cocktail momento — casa del Dr. and Mrs. Robert Counts"; and at 8:00 p.m., the "desinore momento — casa del Dr. and Mrs. Harlan Williams." The dinner featured lasagna, antipasto, vino, spumoni and special fruits. It was a relaxing evening, a fun evening, a money-making evening. What more could anyone ask for? Mrs. Jerome Rini and Mrs. Harlan Williams were cochairmen of this "progressive" party. Mrs. A. L. Berndt was in charge of reservations. Although, as I noted above, the invitations were in Italian, there was one English sentence scrawled across the bottom: "In plain English, an evening of fun for the medical family."

A "This Is Your Life" testimonial program in Oxford climaxed Dr. Fred Shepard Week, celebrated in honor of the College Corner physician of long standing in the area. A group of people estimated at nearly 500 gathered in the Heritage Room of the University Center. Among distinguished visitors for the occasion was Governor Roger D. Branigin, who drove from Indianapolis to pay tribute to his former college classmate.



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525 North Fourth Street

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The OHIO STATE MEDICAL Journal



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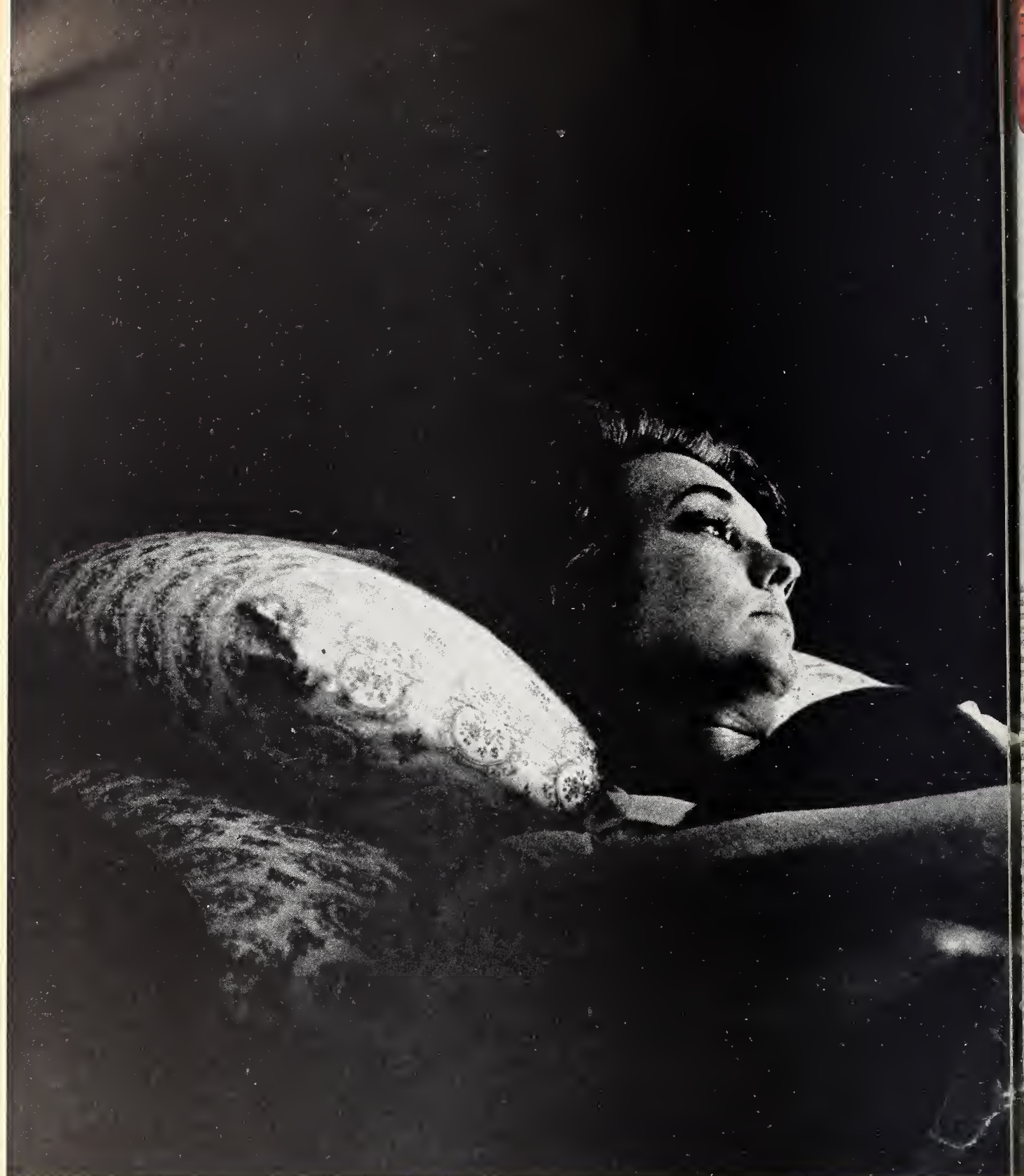
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Indications: Hypertension and many types of edema involving retention of salt and water.

Contraindications: Hypersensitivity and most cases of severe renal or hepatic disease.

Warning: With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery

for these lesions has frequently been required and deaths have occurred. Discontinue enteric-coated potassium supplements immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur.

Use with caution in pregnant patients, since the drug may cross the placental barrier and adverse reactions which may occur in the adult (thrombocytopenia, hyperbilirubinemia, altered carbohydrate metabolism, etc.) are potential

problems in the newborn.

Precautions: Antihypertensive therapy with Hygroton should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents or other potent antihypertensive drugs, or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. Barbiturates, narcotics or alcohol may potentiate hypotension. Because of the possibility of progression of renal damage, peri-

odic determination of the BUN is indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated.

Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, Hygroton should be discontinued and potassium supplements given, provided the patient does not have marked oliguria.

Take special care in cirrhosis or



Diagnosis:

cystitis?
pyelonephritis?
pyelitis?
urethritis?
prostatitis?
in any case,
usually gram-negative*

Therapy:

two 500 mg. Caplets® q.i.d.
(initial adult dose)

Summary of prescribing information

Indications: Urinary tract infections in which gram-negative bacteria are predominant, particularly *Proteus*, *Escherichia coli*, *Aerobacter*, *Klebsiella*, and certain strains of *Pseudomonas*. Gram-positive bacteria are less sensitive to NegGram but favorable clinical results have been observed.

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When testing the urine for glucose in patients receiving NegGram, Clinistix® Reagent Strips or Tes-Tape® should be used since other reagents may give a false-positive reaction.

Adverse reactions: Mainly mild nausea, vomiting, and other gastrointestinal disturbances; less frequently, sleepiness, drowsiness, weakness, headache, dizziness and vertigo, and rarely cholestasis, paresthesia, thrombocytopenia, leukopenia, or hemolytic anemia in patients with a deficiency in activity of glucose-6-phosphate dehydrogenase. Itching, pruritus, rash, urticaria, mild eosinophilia, reversible photosensitivity reactions primarily involving exposed surfaces, and reversible subjective visual disturbances (overbrightness of lights, change in visual color perception, difficulty in focusing, decrease in visual acuity and double vision), occurred occasionally. Reversible increased intracranial pressure with bulging anterior fontanel, papilledema, and headache has been observed occasionally in infants and children. Toxic psychosis and brief convulsions (the latter generally in patients with possible predisposing factors, and both usually associated with excessive dosage) have been recorded in rare instances.

Dosage and administration: **Adults**—Four Gm. daily by mouth (2 Caplets® of 500 mg. four times daily) for one to two weeks. Thereafter, if prolonged treatment is indicated, the dosage may be reduced to two Gm. daily (1 Caplet of 500 mg. four times daily). **Children**—According to age and weight: approximately 25 mg. per pound of body weight per day, administered in divided doses.

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- For children—Caplets of 250 mg., available in bottles of 56 and 1000.

Before prescribing, please refer to complete prescribing information.

References: (1) Based on 23 clinical papers, 1512 cases. Bibliography on request. (2) Bush, I. M., Orkin, L. A., and Winter, J. W., in Sylvester, J. C.: Antimicrobial Agents and Chemotherapy—1964, Ann Arbor, American Society for Microbiology, 1965, p. 722.

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Brand of
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*As many as 9 out of 10 urinary tract infections are now caused by gram-negative organisms: *E. coli*, *Klebsiella*, *Aerobacter*, *Proteus*, *Paracolon* or *Pseudomonas*... However, infections of the urethra and prostate caused by non-gonococcal gram-negative organisms are believed to be less prevalent.

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ACP Cincinnati Program on Intensive Care Units

The American College of Physicians is sponsoring a five-day postgraduate course on "Intensive Care Units in Cincinnati, February 19-23. Details on this and other ACP courses may be obtained from the headquarters office, 4200 Pine Street, Philadelphia, Pa. 19104. The following announcement describes the course:

University of Cincinnati Medical Center and Cincinnati VA Hospital, Cincinnati, Ohio; A. William Schreiner, M.D., F.A.C.P., director; Gene F. Conway, M.D., co-director. Minimal Registration, 10; Maximal Registration, 15.

The course is designed to review recent knowledge and experience in the diagnosis and treatment of patients with critical medical illness and to observe the operation of an intensive care unit, a coronary care unit and related facilities. Topics to be covered will be myocardial infarction, pulmonary insufficiency, shock, cardiopulmonary resuscitation, electrolyte disturbances, stroke, coma, and GI bleeding. Demonstrations and practical experience will be furnished with monitors, respirators, blood gas determinations, defibrillators and cardiac pacing equip-

ment in the Intensive Care Unit, Coronary Care Unit and clinical cardiopulmonary laboratories. There will be discussions of the planning, staffing, and equipping of intensive care and coronary care units.

Cleveland Clinic Foundation Offers PG Courses

The Cleveland Clinic Education Foundation, 2020 East 93rd Street, is offering a number of postgraduate courses during the 1967-1968 season. Details may be obtained by writing to Walter J. Zeiter, M.D., Director of Education, at the foregoing address. The following courses are scheduled in the early part of the year.

January 17-18 — Treatment of Surgical Emergencies.

January 31 - February 1 — General Practice.

February 28 - 29 — Recent Advances in Pediatrics.

March 6 - 7 — Controversies in Urology.

March 20 - 21 — Current Management of Renal Disease.

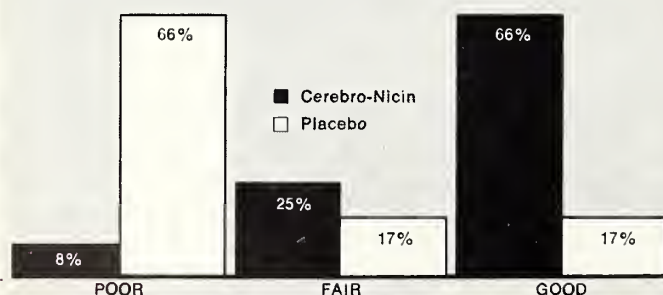
March 27 - 28 — Medical Progress and Its Relationship to Dentistry.

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*A Double-Blind Study of Cerebro-Nicin, Therapy for the Geriatric Patient, R. Goldberg Jr., of the Amer. Ger. Soc., June, 1964

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Medicare Mess

As just about everyone concerned, except the Administration, predicted at the outset, the costs of medicare are exceeding the revenue. Now Welfare Secretary Gardner says the fee for voluntary coverage—that part of the program which pays most of the aged's doctor bills—may have to be increased to \$4 a month, from its present \$3. There is, however, a more logical alternative.

Testifying before a congressional committee recently, the president of the American Medical Association recommended that the Government get out of the administration of medicare's Part B program entirely. He suggested that Social Security payments be increased instead so that beneficiaries can buy their own private voluntary health insurance.

Part B, the AMA official said, has involved the Federal Government itself in "... the practice of medicine through rules, regulations, and statistical data requirements." Moreover, "the patient is dissatisfied because he finds he is getting less than he expected, he experiences delays in being reimbursed, and he can't comprehend the unfamiliar ... combination that is trying to take care of him ... The Congress ... is additionally concerned because it

has created an open-end program with rising and perhaps uncontrollable costs."

The AMA spokesman then raised a fundamental question about medicare as a whole. He pointed out that it covers millions of persons who can afford to finance their own health care, and centralizes direction of the program in Washington rather than permitting the flexibility and trial-and-error of health-care programs administered by the states. He added, "Available tax funds should be used to give maximum health care to those who need help. Expenditures of public funds on those who do not need help limits the resources available to those who do need it."

Secretary Gardner is no doubt correct when he admits, somewhat belatedly, that the Government is collecting less than it costs to run medicare. He is not correct when he suggests the only alternative is to raise the taxes for it.—*Reprinted by Permission from the Toledo Times, October 2, 1967 Issue.*

State Medical Board Licenses M. D.'s for Ohio Practice

The State Medical Board of Ohio authorized 113 doctors of medicine to receive certificates to practice medicine and surgery in Ohio during the period July 31 to October 3, through endorsement of licenses to practice in other states with which Ohio has reciprocity or through certification by the National Board of Medical Examiners.

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Comments on Current Economic, Social And Professional Matters

OMPAC HAS PROVED ITS POWER; DESERVES WHOLEHEARTED SUPPORT

The Ohio Medical Political Action Committee proved its power in the 1966 General Elections — its first real test of effectiveness. It demonstrated that doctors can influence elections — can elect candidates who favor medicine's point of view, and re-elect legislators who have proven themselves worthy of continued public service.

OMPAC proved its effectiveness with the full backing of about one-third of Ohio's doctors of medicine in the 1966 elections. Now — with the 1968 General Elections shaping up — it deserves the backing of every physician in the State who believes in the American way of life and in free elections on which that way of life hinges.

In 1966 OMPAC made financial contributions to 51 candidates for Congress and the Ohio General Assembly. Of that number 45 were elected — and that's an excellent batting average in any league.

Of that number, OMPAC made financial contributions to the campaigns of ten Ohio candidates for the U.S. House of Representatives. Nine of them were elected.

It backed financially 14 candidates for the Ohio Senate, and 12 of those were elected. Of 27 candidates for the Ohio House of Representatives supported financially, 24 were successful.

In addition, OMPAC stirred a tremendous amount of interest in political activities among physicians, their wives, and friends, which resulted in more good candidates being elected.

Remember, this was done with about one-third of Ohio's doctors making financial contributions to OMPAC. Think what it could do with two-thirds of physicians — or 90 per cent — or 95 per cent! Remember also that OMPAC is nonpartisan — it supports good candidates regardless of party affiliation.

Doctor, if you want to help elect candidates to Congress and the Ohio General Assembly who will promote medicine's point of view, or if you want to help re-elect tried and true Congressmen and Legislators, here is the opportunity to join your colleagues in an all-out effort. Join OMPAC for 1968 and make your influence felt in the 1968 General Elections.

COUNTY MEDICAL EXECUTIVE'S INFLUENCE LONG WILL BE FELT

The medical profession lost one of its top executive secretaries recently in the sudden death of Robert F. Freeman, whose outstanding service with the Montgomery County Medical Society speaks for itself. In many ways Bob Freeman typified the metropolitan area executive — a breed which came into its own with the tremendous upsurge of medical organization work during the past several decades.

He took the reins of office in the Dayton office, and relieved physician-officers of much of the tedious administrative details that develop with a growing organization. Today's metropolitan County Medical Society involves many facets of the medical profession's activities, as a glance at an organization committee roster will show.

The activities of many committees must be coordinated; liaison with other organizations in the ancillary services must be maintained; communications must be promoted with the news media and with the community; legislative bodies must be made aware of medicine's point of view; the public's health must be protected; and, all of this in addition to administrative affairs of the Society itself.

Bob Freeman's influence extended beyond the confines of his County Society. He maintained close liaison with the Ohio State Medical Association and with the American Medical Association. He also kept in close touch with his fellow medical executives. He was treasurer of the Ohio Association of County Medical Executives, and president-elect of the American Association of Medical Society Executives.

He assisted and encouraged many young men at the start and during their careers as medical society executives. His sage advice was available to them without stint and was given in a kindly and generous manner. He was respected everywhere and served numerous times on a special evaluation team which has conducted surveys of county medical society operations in all parts of the country, and has made recommendations for increased effectiveness.

He insisted on doctors making the decisions when it came to policy matters, and in this respect he typified a fundamental principle in medical organization work. Bob Freeman's dedicated service has come to a close, but his influence in medical organization work will go on.



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New Members . . .

Following are names of new members of the Ohio State Medical Association certified to the headquarters office during October. List shows name of physician, county, and city in which he is practicing, or in which he is taking postgraduate work.

Allen

James C. Chung, Lima
Eduardo A. Guernica, Lima

Clark

Sreenivasa P. S. Murthy,
Springfield

Cuyahoga

Alejandro M. Aldana Jr.
Cleveland
Sidney M. Cohen, Cleveland
Olgierd Lindan, Cleveland
Leopoldo A. Manzanilla,
Cleveland
Andrey Nicolov, Cleveland
Constantine A. Papas,
Cleveland
Miguel I. Raya, Cleveland
Fritz H. Schulz, Cleveland
Isabel B. Van Doren,
Cleveland

Defiance

Nicholas E. Balmoria, Defiance
Plinio E. Velandia, Defiance

Greene

William K. Neeld, Xenia
Miguel A. Pedraza, Xenia

Hamilton

Omer G. Berger, Cincinnati
John W. Brogan, Cincinnati
Edward R. Brown, Cincinnati
James A. Eha, Cincinnati
Starr Ford, Jr., Cincinnati
John B. Gillen, Jr., Cincinnati
John C. Holmes, Cincinnati

Hamilton—continued

Joseph M. Levin, Cincinnati
Jack E. Payne, Cincinnati
Rodolfo L. Sindiong,
Cincinnati
Earl L. Spiegel, Cincinnati
Antoinette B. Titchener,
Cincinnati
Johanna M. J. Van der
Bel-Kahn, Cincinnati
Stanley J. Wacksman,
Cincinnati
George H. Wierwille,
Cincinnati

Huron

Larry L. Hadley, Monroeville

Lorain

Richard S. Buchanan, Elyria
Maximo A. Oania, Lorain

Lucas

Francesco P. Abbati, Toledo

Mahoning

Albert B. Cinelli,
Youngstown

Ross

Franklin J. Grabill,
Chillicothe
Elias Tomas J. Isa,
Chillicothe
John F. Seidensticker,
Chillicothe

Trumbull

James O. Mattax, Warren

Prescribed Oral Contraceptives And Tax Deduction Ruling

The October 9 issue of the Internal Revenue Bulletin contained the following ruling pertaining to Section 213, of the Internal Revenue Code:

A taxpayer's wife almost died during the birth of her second child by Caesarean section. As a result, their family physician recommended that the taxpayer and his wife have no more children because of her age and the danger involved. The physician prescribed the use of oral contraceptives for the prevention of further conception and childbirth.

Held, where, under the above circumstances, in the opinion of the physician the possibility of childbirth raises a serious threat to the life of the wife, and as a result of such threat he prescribes the use of oral contraceptives for the purpose of preventing any further conception and childbirth, the amount expended for the oral contraceptives is an amount paid for medical care, as defined in section 213(e) of the Internal Revenue Code of 1954, and is deductible under section 213 of the Code subject to the limitations provided for therein.

Ultramodern Surgical Suite at Western Reserve Opened

The \$3,000,000 Dudley P. Allen Surgical Suite, described as one of the most modern and complete surgery facilities in the country, opened recently in the Robert H. Bishop Building of the University Hospitals of Cleveland.

The new suite occupies the entire second floor of the Bishop Building, an area of approximately 38,000 square feet. It contains 26 operating rooms, separate adult, pediatric, and ambulatory recovery rooms, and a large centralized work area to provide supporting services.

Opening of the suite completed the \$10.6-million Bishop Building, which required three years for construction. It is the first project to be completed in the extensive University Medical Center Development Program, a joint expansion program for the Health Science Schools of Case Western Reserve University and the affiliated University Hospitals.

The surgical suite embraces many advanced features, such as:

Separate operating rooms for each of nine sur-

gical specialties, including a special pediatric surgery area.

Ambulatory facilities, including dressing rooms, a lounge, and a recovery room, for minor surgical operations.

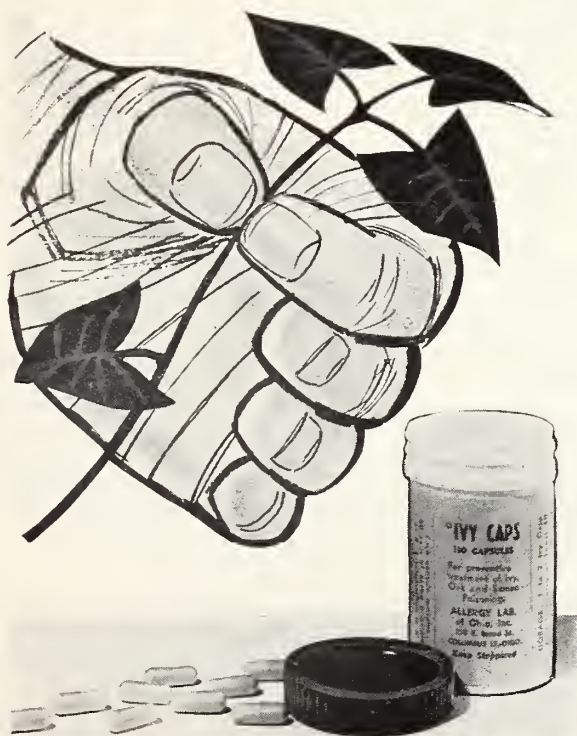
Closed-circuit television hookups in the operating rooms for the future telecasting of surgical procedures as a teaching aid for medical and nursing staff and students participating in related teaching programs at Case Western Reserve University.

A 35-channel intercom net which permits direct communication between operating rooms and service facilities.

A central supply system for oxygen, nitrous oxide and compressed air which connects to an automatic central alarm system.

Five of the new operating rooms are designated for general surgery. The other operating rooms are earmarked for the various surgical specialties, such as neurosurgery, cardiac surgery, thoracic surgery, orthopedic surgery, plastic surgery, pediatric surgery, urology, otolaryngology, and ophthalmology.

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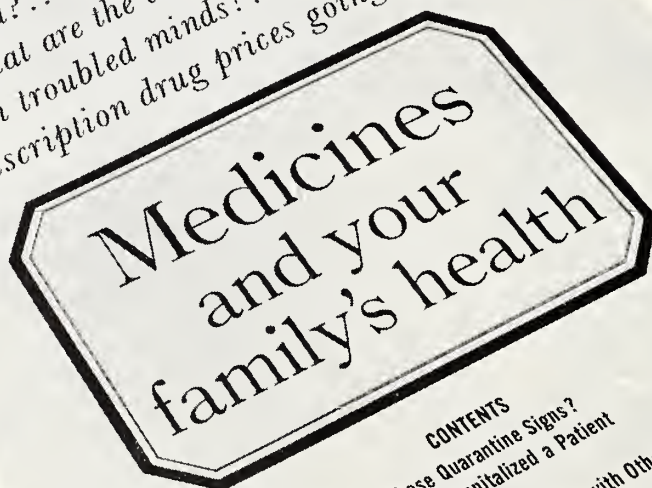
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...What are the drugs that
reach troubled minds? ...Where are
prescription drug prices going?



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CONTENTS
What Ever Became of Those Quarantine Signs?
The Anonymous Drug That Hospitalized a Patient
Medicines for the Troubled Mind
How Does the Price of Medicine Compare with Other Prices?
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of The Reader's Digest

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Ohio Medical Education Network Now in Its Sixth Season

Ohio State University's Ohio Medical Education Network (OMEN) began its sixth season of FM radio broadcasting October 16.

The network links faculty members of Ohio State's College of Medicine with physicians assembled at 61 hospitals in Ohio, and in neighboring areas of Pennsylvania, Kentucky, and West Virginia in discussions designed to keep active physicians aware of new developments in medicine.

Over 100 hour-long programs are on the schedule of broadcasts this year by OMEN, and an additional 28 nursing programs are being produced by the Ohio Nurses Continuing Education Program, a counterpart to OMEN which was started last year. Each program has two parts—a half-hour formal talk given by a faculty member, followed by a half-hour question and answer period.

Between 12,000 and 20,000 doctors and nurses will comprise the professional audience for the radio programs in the four-state area this year. The programs will also be heard by other persons who can tune in on one of 13 local FM stations in Ohio and West Virginia. The stations have a network line hookup to WOSU-FM, the Ohio State University radio station.

Originating from a studio in the College of Medicine, the programs are directed to a different set of 12 hospitals each day, Monday through Friday. Scheduling is done so that members of the audience at each hospital have ample time to ask questions and make comments. Although the formal talk is repeated five times, the question and answer portion of each program differs since a different set of hospitals is involved for each broadcast.

As well as Ohio State faculty, physicians from other medical schools in Ohio, New York, and North

Carolina are on the program for the 1967-68 season. Discussions will involve such medical problems as immunization, coronary disease, the emergency room, alcoholism, cancer, and others.

Conceived in late 1961, the Ohio Medical Education Network came into existence in October, 1962, with two FM stations and 12 central Ohio hospitals participating. In five years, OMEN programs have had about 51,000 registered attendances in network hospitals.

Last year, OMEN received an award for creativity from the National University Extension Association's division of conferences and seminars.

Authorized for continuation study credit by the American Academy of General Practice, the network is supported in part by grants from the Merck, Sharp and Dohme Postgraduate Program and the American Cancer Society.

In addition to Ohio State's network, there are at least seven other medical institutions using the technique which serves physicians in 18 states.

Cincinnati Dean Emeritus Given National Honor

American medicine's highest honor for distinguished service to medical education has been given to Dr. Stanley E. Dorst, dean emeritus of the University of Cincinnati College of Medicine.

The Association of American Medical Colleges, naming Dr. Dorst for its 1967 Abraham Flexner award, has paid tribute to his "illustrious career as physician, teacher, energetic, and intellectually stimulating dean, and, more particularly, his innovative and productive leadership in medical education."

Dr. Dorst was dean from 1940 to 1963. He was president of AAMC in 1952-1953.



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Columbus Physician Honored for National Guard Service

A Columbus physician recently was honored with the Army's Legion of Merit award for the second time in his career. Colonel Anthony Ruppertsberg, Jr., was presented the citation and decorated with the award in ceremonies at Fort Hayes in Columbus. Major General Erwin C. Hostetler, Adjutant General of Ohio, presided at the ceremonies, and Colonel Hubert Strange, commander of the 20th Army Corps, under whose command the Ohio National Guard operates, made the presentation.

Colonel Ruppertsberg, a practicing physician in Columbus, retired from the National Guard last June after 34 years of service. He was cited for outstanding administrative work as chief of staff of the National Guard and as state surgeon general.

On the occasion of his retirement this summer, Colonel Ruppertsberg was honored before a troop review at Camp Perry. He was given the Army Commendation Medal at that time.

His first Legion of Merit award was for outstanding service as commander of a station hospital in the Fiji Islands during World War II.

Dr. Ruppertsberg, whose specialty is obstetrics and gynecology, for many years has been chairman of the Ohio State Medical Association's Committee on Maternal Health, a group which has carried on an

outstanding service by studying maternal mortality in Ohio and thus pointing the way to better obstetrical practices.

Schools of Allied Medical Services Join in National Organization

The Ohio State University School of Allied Medical Services has become one of 13 charter members of a new association of Schools of Allied Health Professions. Robert J. Atwell, M. D., director of the school, has been elected to the association's executive committee.

Besides the original 13 schools, 20 additional colleges throughout the country are in the process of forming degree programs in health related fields. By December, 1968, 60 colleges are expected to be participating in such programs, it was predicted.

East Liverpool Heart Program

The East Liverpool City Hospital medical staff presented the Joan Smith Heart Lecture at the East Liverpool Country Club, where a social hour and dinner followed the program on November 9.

Speaker for the occasion was Dr. William L. Proudfit, head of the Department of Clinical Cardiology, Cleveland Clinic, whose subject was "Developments in the Diagnosis and Treatment of Coronary Artery Diseases."

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Scientific Section

VOL. 63

DECEMBER, 1967

No. 12

Pulmonary Function in Sarcoidosis*

ROBERT B. PACKER, M.D.

SARCOIDOSIS is a granulomatous, inflammatory, systemic disease of unknown etiology. Its course may be chronic with relapses and remissions, it may progress steadily to death, or there may be complete resolution of the disease. The extent of disability depends on the organ system involved. While it is not a common disease, it can, by no means, be considered rare. A five year study of admissions to United States Army hospitals throughout the world (1952-1956) revealed a mean incidence rate of 10 cases per 100,000 admissions.¹ Chest x-ray surveys of 1,000,000 inhabitants of Sweden between 1950 and 1954 detected almost half as many cases of sarcoidosis as of tuberculosis.² The peak incidence of sarcoidosis is in the third and fourth decades with slightly more females than males becoming affected. In the United States, Negroes are more frequently afflicted than Caucasians.

Although sarcoidosis is a systemic disease it most frequently involves the respiratory system. Ninety-five per cent of the patients studied by Israel and Sones had roentgenological evidence of pulmonary or tracheobronchial lymph node involvement.³ The mortality rate of nearly 10 per cent is almost exclusively secondary to diffuse pulmonary fibrosis.⁴ The extensive fibrosis may eventually lead to fatal hypoxia and carbon dioxide retention, i. e., respiratory insufficiency.

In addition to respiratory insufficiency, the patient's death may be accelerated by the development of cor pulmonale. Distortion and destruction of the

The Author

● Dr. Packer, Atlanta, Georgia, former Medical Resident at the Veterans Administration Hospital, Cleveland, currently is fulfilling military obligation, on duty with the U.S. Public Health Service in the Laboratory Branch, National Communicable Disease Center, Atlanta.

pulmonary vascular bed by granulomatous and fibrous tissue, plus polycythemia, when present, may be factors which lead to pulmonary hypertension and perhaps cor pulmonale. More important, however, is the development of hypoxia, which causes reflex vasoconstriction of the pulmonary vasculature. The hypoxia acting alone or interacting with diminished pulmonary vascular bed and polycythemia may produce pulmonary hypertension.⁵

A compromised respiratory system is the most common cause of physical disability in patients with sarcoidosis. Therefore, it is important for the physician to appreciate the pathophysiology of pulmonary sarcoidosis and the value of pulmonary function studies in following the course and management of these patients.

Pathology

Pathologically, sarcoidosis is a granulomatous disease. The granulomas, on microscopic examination, are composed of large pale staining epithelioid cells and may contain giant cells. In contrast to tuberculosis, the granulomas found in sarcoidosis usually have little or no peripheral cuffing with nonspecific

*From the Pulmonary Section, Medical Service, Veterans Administration Hospital and the Department of Medicine, Western Reserve University School of Medicine, Cleveland, Ohio. Submitted May 16, 1967.

inflammatory cells, do not caseate, and seldom coalesce. The granulomas may resolve completely or leave a residual of hyaline or fibrous tissue.

On gross examination, pulmonary sarcoidosis may show gray-yellow, firm, small nodules, fibrosis with honeycombing, emphysematous blebs, and/or bronchiolectasis.

The granulomas tend to form around lymphatics in peribronchial, perivascular, and subpleural areas. In addition, they are found in the alveolar lumen, bronchial, or vessel wall. With peribronchial and perivascular involvement, the mucosal and endothelial surfaces are preserved. The significance of the anatomical localization of the lesions in relation to the functional respiratory abnormalities will be discussed later.

Classification of Pulmonary Lesions

Radiographically, four distinct intrathoracic patterns are seen.

1. Hilar adenopathy without pulmonary parenchymal involvement. Characteristically, the node enlargement is usually localized to the paratracheal, tracheobronchial, or bronchopulmonary groups of nodes. The enlargement is usually symmetrical and seldom affects the retrosternal nodes. These two characteristics help to distinguish it from lymphoma which is usually asymmetrical and does affect retrosternal nodes.⁶

2. Diffuse pulmonary disease without lymph node enlargement. The pulmonary disease is usually diffuse, most commonly reticulonodular and evenly distributed from apex to base.⁶

3. Combination of hilar adenopathy and diffuse parenchymal disease. The fluffy parenchymal infiltrates occasionally seen in types 2 and 3 may be mistaken for acute pneumonitis or metastatic tumor.

4. Pulmonary fibrosis. This pattern consists of persistent strand-like densities; retraction or distortion of the hila, fissures, or mediastinal structures; and multiple cysts.⁷

Functional Abnormalities

Hilar Adenopathy

Hilar adenopathy is often considered a benign manifestation of sarcoidosis. It is true that 71 per cent of patients with hilar adenopathy will show some improvement and 61 per cent will show complete resolution.⁸ However, in spite of the encouraging radiological picture, a significant number of patients have functional abnormalities during and after resolution of the adenopathy.⁹⁻¹¹

Reduced static lung volumes (vital capacity, total lung capacity, residual volume, functional residual capacity) have been reported by a number of investigators.⁹⁻¹⁴

Pulmonary compliance, an expression of lung elasticity, is also reduced in some patients. Specific compliance, a more exact measurement of lung

stiffness, has been reported to be normal as well as abnormal. Marshall, *et al.*¹² commented that it was "surprisingly normal" in 22 of 26 patients with all degrees of pulmonary sarcoidosis that they studied. On the other hand, Young, *et al.*¹³ found that specific compliance was decreased in 14 of 17 patients and increased in the other three. Their group also included patients with fibrosis as well as infiltrates and adenopathy alone. It will be recalled that compliance is the unit change in lung volume per unit change in pressure, i. e., $\frac{\Delta V}{\Delta P}$ expressed in liters per cm. of water. The greater the compliance the easier it is to inflate the lung.

Specific compliance is defined as pulmonary compliance divided by the functional residual capacity (FRC). The FRC is the amount of air left in the lung at the end of a normal expiration. This is an important consideration, because the compliance of the lungs changes directly with changes in the FRC.¹⁵ As noted above, the FRC is decreased in patients with hilar adenopathy. Thus, the compliance is decreased when the FRC is not taken into consideration but may be normal when expressed as specific compliance.

In addition to the decreased static lung volumes and decreased pulmonary compliance, the diffusion capacity of the lung or pulmonary diffusing capacity (D_L) is decreased in many patients with bilateral hilar adenopathy.^{9-14,16} Pulmonary diffusing capacity is defined as the rate of gas diffusion in ml. STPD* per minute divided by the pressure difference in mm. mercury between alveolar air and the interior of the red blood cell.¹⁷ This includes the entire diffusion path for the gas, from the alveolus to the hemoglobin molecule. Either carbon monoxide (CO) or oxygen (O_2) may be used to measure D_L in the laboratory. Carbon monoxide is most frequently used. The result is expressed as the ml of O_2 or CO/min/mm Hg. Pulmonary diffusing capacity is influenced by intrapulmonary gas mixing as well as by other factors which will be discussed under functional pathologic correlation.

The patients with hilar adenopathy alone reported by Boushy, *et al.*⁹ had abnormal diffusing capacities during the presence of the adenopathy and four of the five had persistent abnormalities even after the adenopathy cleared. Persistence of abnormal D_L after resolution of the adenopathy has more recently been emphasized in two papers by Sharma, *et al.*^{10,11} Their first paper reports the pulmonary function results in 18 patients with bilateral hilar adenopathy without pulmonary infiltrates on x-ray.¹⁰ Thirteen of these 18 patients had pulmonary diffusing capacities below 80 per cent or normal; their lower limit of normal. Ten of these patients were studied two months to five years after their original evaluation. Of these 10, four showed regression of the hilar

* Standard Temperature Pressure Dry.

nodes and six, no change. Eight of the 10, however, showed further reduction of pulmonary diffusing capacity in spite of the fact they were asymptomatic. None of the patients was treated with corticosteroids.

The second paper by Sharma, *et al.*¹¹ presents the data of a more comprehensive study of 43 patients including those with diffuse pulmonary infiltrates and fibrosis as well as those with bilateral hilar adenopathy followed over a six year period. Twenty-eight of the 43 patients received no corticosteroids. Eleven of the 28 showed either complete or partial resolution of the adenopathy or infiltrate and adenopathy. Of these 11, only two did not show an abnormal pulmonary diffusing capacity after the resolution.

Thus, there is ample evidence to show that roentgenologic clearing of hilar adenopathy does not mean the lung has been left unharmed physiologically.

Diffuse Parenchymal Disease With or Without Adenopathy

Decreased static lung volumes, decreased compliance with normal or abnormal specific compliance, and decreased pulmonary diffusing capacity are also frequently seen in patients with diffuse parenchymal infiltrates with or without adenopathy. The degree of abnormality is not necessarily more severe than in the patients with adenopathy alone. As is the case of those patients with adenopathy alone, radiographic clearing is frequently not accompanied by physiologic improvement.^{9,11} Also, the amount of functional impairment does not correlate well with the extent of roentgenologic change.^{12,18} This lack of correlation applies to those patients with hilar adenopathy without parenchymal infiltrates as well.

Pulmonary Fibrosis

Parenchymal fibrosis is the most severe manifestation of pulmonary sarcoidosis. As mentioned earlier, it is in this group of patients that morbidity and mortality are greatest. Again, decreased static lung volumes, decreased compliance with relatively normal or abnormal specific compliance, and impaired diffusing capacity are the most common functional abnormalities. As might be expected from the severity of the symptoms displayed by these patients, they have the greatest degree of functional impairment.⁹ West and Alexander¹⁹ demonstrated that patients with pulmonary fibrosis have inelastic, stiff lungs, which require a greater amount of work for inflation than do normal lungs. They also showed that the fibrotic lung reaches its limits of distensibility at a smaller volume than does the normal lung. Thus, in order to maintain a normal minute volume, patients with pulmonary fibrosis must increase their respiratory rate. This, in part, accounts for the tachypnea seen in these patients at rest.

Functional abnormalities consistent with obstructive airway disease have been reported with all stages of pulmonary sarcoidosis; however, they are not common. They may represent chronic obstructive airway disease coexisting with pulmonary sarcoidosis or may reflect peribronchiolar involvement with granulomatous or fibrous tissue.

Functional Pathological Correlations

Decreased lung volumes are presumably a consequence of normal alveoli being replaced by granulomatous and, eventually, fibrous tissue.^{12,14}

Replacement of normal lung with granulomatous and relatively inelastic fibrous tissue is probably the cause for decreased compliance and specific compliance when it is abnormal. As discussed earlier, however, the reduction in FRC can lead to a decreased compliance but a normal specific compliance.

Pulmonary diffusing capacity is influenced by (1) the average thickness of the pulmonary membrane, (2) the surface area available for diffusion (this is defined as the number of functioning alveoli in contact with functioning capillaries), and (3) the nature of the alveolar-capillary membrane.^{15,20} Destruction and thickening of the alveolar-capillary membrane as well as destruction of the capillary bed have been demonstrated microscopically.^{21,22} Both of these alterations could theoretically reduce diffusing capacity. Finley, *et al.*²³ have demonstrated that reduced diffusing capacities can be produced by uneven distribution of ventilation to blood flow ratios (ventilation perfusion abnormalities). That is, areas of lung without blood flow are ventilated and some without ventilation are perfused with blood. As a consequence, no blood is exposed to oxygen.

The authors showed mathematically that considerable thickening of the alveolar-capillary membrane must occur before there is a significant decrease in diffusion. Since thickening of the walls of some of the smaller alveoli could essentially "fill them in" they would lose their ventilation but still might continue to be perfused producing, in essence, an arteriovenous shunt.²³ The same authors offer further support for uneven ventilation to blood flow ratios as a cause of decreased diffusing capacity by pointing out that alterations in compliance caused by fibrosis would result in diseased alveoli being poorly ventilated. If such poorly compliant alveoli continued to receive blood flow, uneven ventilation to perfusion ratios would again result.

Endobronchial and peribronchiolar granulomas and fibrosis have been shown to be present in those cases with evidence of increased airway resistance.²⁴ Young, *et al.*¹³ found the small airways of a number of their patients to be involved with granulomata even though they had no functional evidence of obstruction. They felt the absence of obstructive

findings could be explained by the very large total cross sectional area and consequent low airway resistance of the smaller airways where the granulomata were found. On the other hand, granulomata in the larger, less numerous bronchi could cause increased airway resistance.

Treatment and Function

A number of studies have been done evaluating the pulmonary function before and after corticosteroid or ACTH therapy.^{9,11,25-29} In evaluating the effect of therapy on pulmonary sarcoidosis, one should keep in mind that 71 per cent of the patients with hilar adenopathy will show some spontaneous clearing within two years (61 per cent complete clearing) and that roughly 50 per cent of patients with pulmonary infiltrates with or without adenopathy will show spontaneous improvement within one year.⁸ Also striking improvement may occur in the radiograph unaccompanied by improvement in pulmonary function.²⁵ Patients with hilar adenopathy and pulmonary infiltrates with or without adenopathy usually show an increase in static lung volumes and compliance with treatment. Those with pulmonary fibrosis appear to have fixed abnormalities.²⁶ Abnormal pulmonary diffusing capacity usually does not improve and, even when it does, seldom returns to normal.^{9,11,25} Stone and Schwartz²⁹ concluded that steroid therapy may be beneficial in isolated instances but that there was no conclusive evidence that it altered long-term prognosis. Sharma, *et al.*¹¹ demonstrated that corticosteroids (prednisone 20 mg daily) produced improvement in all but one of their patients with severe impairment of pulmonary function (D_L below 65 per cent of normal) but that cessation of therapy caused reversion to previous status in most patients. Corticosteroid therapy had no consistent beneficial effect on their patients with mild functional impairment.

Correlation of Radiograph and Pulmonary Function

Ting and Williams¹⁸ demonstrated little correlation between the degree of radiologic change and functional impairment. Marshall, *et al.*¹² however, did note that, when fibrosis was present on x-ray, compliance, lung volumes, and D_L were invariably impaired. Hamer¹⁶ presented evidence showing that the longer the infiltrate was present the greater the abnormality of pulmonary diffusing capacity. The important point to remember is that patients with hilar adenopathy alone do demonstrate abnormalities of pulmonary function and that structural change can occur in the lung without being detected by x-ray.¹³

Summary and Conclusions

The purpose of this paper has been to point out the importance of pulmonary function studies in patients with pulmonary sarcoidosis. Patients with

all degrees of radiologic change from adenopathy to extensive fibrosis may show abnormalities of static lung volumes, compliance, or diffusing capacity and occasionally airway resistance. The degree of radiographic change seems to correlate with functional changes only when fibrosis is present. Evidence from several studies indicates that pulmonary diffusing capacity may not return to normal after radiologic clearing. Steroid therapy seems to be beneficial only in patients with severe functional impairment, and relapse may be expected when therapy is stopped.

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Methacycline in Urinary Tract Infections

Clinical Trial of a New Antibiotic

WILLIAM MULVANEY, M.D., EMIL GRITTI, M.D., and RUDOLPHO SINDIONG, M.D.

METHACYCLINE* is a new, broad-spectrum antibiotic synthesized from oxytetracycline. It is a yellow, crystalline compound obtained as a hydrochloride salt ($C_{22}H_{22}O_8 \cdot HCl$). Studies on animals demonstrated that methacycline possesses a typical tetracycline microbiological spectrum, but that it is somewhat more potent than demethylchlortetracycline, tetracycline, or oxytetracycline. Although methacycline undergoes fairly rapid degradation when dissolved in pH 7.5 buffer or nutrient broth at 37°C, this degradation is strongly repressed, in solutions containing at least 25 per cent human serum, with a stability pattern similar to demethylchlortetracycline. In dogs, appreciable levels of the drug appear in the bile, whereas cerebrospinal fluid concentrations are very low. With intravenous administration 48 per cent is recovered in the urine, but this level drops to only 7 per cent after administration by the oral route.

The present paper concerns a clinical trial of methacycline in treatment of infections involving both the upper and the lower urinary tract. The infections treated were of various etiologies and degrees of severity. They were manifest in symptoms of cystitis, prostatitis, prostatic abscess, and other acute and chronic conditions afflicting adults of both sexes and constituted a picture representative of the ordinary clinical setting in which urinary tract infection appears.

Methods and Materials

Subjects included 51 adult patients, all with urinary tract infections as diagnosed through urine cultures on which bacterial identifications were made. There were 33 men and 18 women, ranging in age from 24 to 81 years, with a mean age of 51 years and an average weight of 154 lbs. Thirty-one were treated as outpatients, 13 as hospital patients, and seven in both capacities at different times.

The diagnoses were classified under upper urinary tract and lower urinary tract infections (cystitis, prostatitis, prostatic abscess, etc.) and were further subdivided as acute or chronic.

Sensitivity tests on the present cultures were conducted by the disc method for methacycline as well

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as the other tetracycline drugs. Other laboratory tests, performed before and after therapy, included complete blood count, urinalysis, and measurements of blood urea nitrogen (BUN) and serum glutamic oxalo-acetic transaminase (SGOT).

Methacycline was administered in doses of 300 mg, capsule twice a day for eight days. Two patients who took the drug for eight days were returned to the medication for an additional eight-day period after a few days' interval. Another subject received methacycline for a total of 32 days.

Responses to methacycline therapy were evaluated according to the following criteria:

Good—A definite favorable response, with alleviation of symptoms within 48 hours, and a negative culture or a negligible bacterial count after discontinuation of therapy.

Fair—A slight favorable response observed, but with symptoms persisting longer than 48 hours, and with a negative culture or a significant decrease in the bacterial count after discontinuation of therapy.

Poor—No alleviation of symptoms, or actual worsening of the patient's status, with the culture remaining positive and only a slight decrease, at best, in the bacterial count.

Results

Of the 51 subjects in the present study, infection involved the upper urinary tract in 20 and the lower urinary tract in 31. Twenty-one infections were classified as acute, and 30 as chronic. These diagnostic categories are related to therapeutic responses in Table 1.

Submitted May 19, 1967.
*Rondomycin®, Pfizer Laboratories.

TABLE 1. *Therapeutic Response According to Diagnostic Categories*

INFECTION	RESPONSE		
	Good	Fair	Poor
<i>Upper Urinary tract</i>			
Acute	3	1	2
Chronic	7	4	3
<i>Lower Urinary tract</i>			
Acute	12	2	1
Chronic	7	5	4
Total	29	12	10

As is seen in the Table, *good* response was obtained in 29 patients, *fair* response in 12, and *poor* response in the remaining 10. It may also be observed that favorable response occurred in a greater proportion of the acute cases than of the chronic cases, as might have been expected.

Seven of the 10 subjects showing *poor* responses to methacycline treatment had chronic infections. All of these seven patients had previously been treated with other antibiotics, including chloramphenicol, nalidixic acid, sulfisoxazole, and nitrofurantoin; in each case, poor response had resulted from this previous therapy as well.

Of 58 bacterial strains isolated in cultures from the present subjects, 22 strains appeared susceptible and 36 resistant to methacycline by disc tests. The discrepancy between the good clinical results of methacycline treatment and the relatively low proportion of susceptible organisms reflected by these *in vitro* tests may be due to insufficient concentration of the drug in the disc and also to the inherent shortcomings of sensitivity testing by the disc method as opposed to the tube dilution method.

TABLE 2. *Therapeutic Response According to Organisms Isolated*

ORGANISM	RESPONSE		
	Good	Fair	Poor
<i>Escherichia coli</i>	13	7	5
<i>Streptococcus mitis</i> .....	..	2	..
<i>Aerobacter aerogenes</i>	5	2	1
<i>Escherichia freundii</i>	1	..	1
Non-hemolytic streptococcus	1	..	..
<i>Proteus mirabilis</i>	3	1	2
<i>Proteus rettgeri</i>	1	1	..
<i>Proteus vulgaris</i>	1	1	1
<i>Pseudomonas morganii</i>	1	1	..
<i>Pseudomonas aeruginosa</i>	1	2	1
<i>Staphylococcus aureus</i>	1	..	..
<i>Klebsiella aerobacter</i>	2	..	..
<i>Paracolon bacillus</i>	1	1	..
<i>Streptococcus faecalis</i>	1	..	1
(No growth)	1	..	..
Totals	31	18	11

Table 2 shows the various organisms cultured from the present subjects and their responses to methacycline treatment. A few patients had mixed infections. *Escherichia coli* was the organism found most frequently in these infections, with the *Proteus* group, *Aerobacter*, and *Pseudomonas* following, in that order. Methacycline appeared surprisingly more effective in infections with *Proteus* and *Pseudomonas* organisms than might have been expected.

Comparative sensitivity tests indicated that a greater proportion of the organisms isolated were susceptible to methacycline (22 susceptible out of 58 tested) than were susceptible to tetracycline (10 out of 54), oxytetracycline (6 out of 26), or demethylchlortetracycline (4 out of 42).

There were no overall significant changes in the blood chemistries during therapy. Four patients showed the following changes: eosinophils increased from 2 to 5 per cent; lymphocytes decreased from 32 to 20 per cent; monocytes increased from 5 to 7 per cent; polymorphonuclear leukocytes decreased from 59 to 51 per cent and lymphocytes increased from 31 to 40 per cent.

Among the 51 patients taking methacycline, there were no serious ill effects from the drug. Four subjects noted minor reactions, but whether or not these were attributable to the drug could not be ascertained. Of these four subjects, one reported moderate nausea, which abated with the administration of oral alkali; this patient was taking stilbestrol for carcinoma of the prostate, and the specific cause of the nausea is quite uncertain. A second subject reported anal pruritus, which he had also experienced on one previous occasion. Mild heartburn was noted by another patient. One other subject reported itching between the fingers two weeks after therapy; it is questionable as to whether methacycline caused this reaction, which disappeared in three days with heat treatment.

Finally, it might be noted that observations concerning these subjects suggest that the fluorescent properties of methacycline are similar to those of other tetracycline drugs. These properties and their applications are discussed in a previous publication by one of the present investigators.¹

Long-Term Therapy with Methacycline

Four patients with chronic urinary tract infections requiring long-term antibiotic therapy presented an opportunity to determine the pertinent effects of methacycline over periods longer than that concerned in the study described above. The results of this long-term therapy are submitted in the following case histories as data of interest in relation to the results of short-term therapy in the present study.

Case 1. A 42-year-old man presented chronic recurrent cystitis and old prostatitis with some vesical neck obstruction. He had been treated with Furadantin®, sulfonamides, and Urobiotic®. Urine culture showed *E. coli*, which was highly susceptible to Coly-Mycin®, moderately susceptible to sodium carboxymethyl cellulose (CMC®), Furadantin, Keflin®, Polycyline®, and polymyxin, and resistant to other antibiotics tested. He began taking methacycline (300 mg. twice a day) on February 10, and stated that this was the only drug that had given him relief from dysuria. He continued this medication until March 4, and promptly developed recurrence of his symptoms on discontinuing it. He again took the drug, starting on April 5, and continued on the same dosage for a period of two months, except for an interval of several days, during which time he developed pyuria and dysuria. The BUN, SGOT, and blood count were normal. The culture was still not sterile, but urinalysis became negative while

he was treated with the drug. There were no untoward effects.

Case 2. A 68-year-old man developed a chronic urinary tract infection following removal of a kidney with a stag-horn calculus in chronic pyelonephritis. The laboratory findings were unremarkable. He was given methacycline 300 mg. twice a day. Improvement of the pyuria was obtained. It was then found that he had prostatic hypertrophy with obstruction. He was maintained on therapy for a six-week period; during the second week, a trans-urethral prostatectomy was performed. There were no untoward effects of methacycline, and SGOT and BUN were normal after four weeks. After six weeks, culture evidenced *Pseudomonas* organisms, but the pyuria had improved. Subsequently, he was given further treatment with Furadantin; the urine cleared and became sterile. There were no side effects from the long-term treatment with methacycline.

Case 3. A man presented chronic cystitis with an underlying *E. coli* organism, which showed sensitivity only to Chloromycetin® and Mandelamine® in *in vitro* disc studies. There was chronic epididymo-orchitis and a recurrent urethral stricture. He was treated for two weeks with methacycline with improvement of the symptoms of epididymitis and reduction in size of the testis and epididymis. Urinalysis became almost clear, showing 3 to 5 white cells per low power field. SGOT, BUN, and blood cell count were normal at this point. Subsequently, he was maintained on methacycline for a period of six weeks by his private physician. There were no side effects noted, and symptoms of the infection were minimal. At the end of that time, a few cells persisted in the urine, but the patient was asymptomatic.

Case 4. A 78-year-old man with carcinoma of the bladder, also presenting an *E. coli* infection, was treated with methacycline with the idea of treating the infection, and also to see if fluorescence of the tumor could be produced before surgery. His BUN, SGOT, and blood cell count were unremarkable. He had been bothered by bleeding intermittently and felt that the methacycline reduced the bleeding. Accordingly, he requested that he be allowed to continue this medication. He was given 300 mg. two

times a day for a period of six weeks. Urinalysis showed red and white blood cells. The culture after discontinuation of medication was negative, and the SGOT, BUN, and blood count were unremarkable, except for anemia due to bleeding from the tumor. At surgery, some fluorescence of the necrotic areas was found under ultraviolet light. There were no untoward effects from methacycline.

Summary

Methacycline is a new broad-spectrum antibiotic which was subjected to clinical trial in 51 adult patients who had urinary tract infections. Of this group, 29 patients showed a good response to the drug, and 12 patients showed a fair response. This represents an overall favorable clinical response to methacycline of 80 per cent.

Methacycline was found to be most effective against *E. coli* and *Aerobacter aerogenes* bacteria. A high number of acceptable clinical responses was encountered in the cases associated with *Proteus* and *Pseudomonas* organisms.

The present results indicate that methacycline is an effective antibiotic to employ in treatment of urinary tract infections, both acute and chronic. It appears to be quite safe and, in the present group of patients, was free of toxicity and serious side reactions. These conclusions are further confirmed by results of long-term therapy in four additional cases reported.

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MALIGNANT HYPERTENSION. — Twenty patients with malignant hypertension and blood urea nitrogen concentration of 50 mg. per 100 ml. or higher were selected to determine whether the survival rate could be improved by aggressive utilization of hypotensive drugs and careful attention to fluid and electrolyte metabolism, as well as to evaluate the validity of the impression that reduction of blood pressure in such patients is accompanied by further rapidly progressive deterioration of renal function.

Of the 11 (55 per cent) who lived for one year, 9 (45 per cent) are still alive. The follow-up period is approaching four years in 2, between two and three years in 2 and between one and two years in 5.

In the surviving patients, the glomerular filtration rate has decreased slightly in 1, remained unchanged in 3 and increased an average of 15 ml. per minute in 5.

Reduction of blood pressure in patients with malignant hypertension complicated by renal insufficiency does not necessarily result in deterioration of renal function and may result in improved survival rates. — James W. Woods, M.D., and William B. Blythe, M.D., Chapel Hill, North Carolina: *The New England Journal of Medicine*, 277:57-61, July 13, 1967.

Regional Center for Mentally Retarded

LESLIE Y. CH'ENG, M.D.

THE REPORT of the President's Panel on Mental Retardation begins with the statement: "The Mentally Retarded are children and adults who, as a result of inadequately developed intelligence, are significantly impaired in their ability to learn and to adapt to the demands of society. An estimated 3 per cent of the population, or 5.4 million children and adults in the United States, are afflicted, some severely, most only mildly."¹

An estimated 60,000 to 90,000 persons, mostly children and adolescents, are profoundly or severely retarded. They need constant care or supervision throughout their lives if they are to survive. Modern medical science has succeeded to prolong the life span of many such persons, but the majority of them still will not reach adulthood. It is estimated that somewhat over 4,000 births a year fall in this group.

An estimated 300,000 to 350,000 individuals are classified as moderately retarded persons. They are capable of developing self-protection skills for semi-productive effort so they can contribute partially to their self-support if given an adequately protected environment. They are unlikely to progress beyond a mental age of 7 years even in adulthood. Modern medical science contributes to increasing life span of these individuals.

Approximately five million persons comprise the mildly retarded group, the largest group of all. They are usually not distinguishable from normal individuals (average Americans), until school age, and sometimes fourth grade and thereafter, when they are then identified by an inability to learn general school subjects. They are the workers who are the most frequently displaced by the economic adjustment in our competitive society. Upon leaving the compulsory school system, many of them join and eventually merge in the group of unskilled or semi-skilled laborers.

This last group resembles really more the normal population than the first two groups. They are "normal population" with somewhat subaverage intellectual capability, particularly as this capability is measured by the yardsticks which we call intelligence tests—which are largely dependent on academic knowledge, racial and cultural traditions.² This explains the fact that during World War II, the percentage rejected for "mental deficiency"

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ranged from 1 per cent in the Far West States to nearly 10 per cent in the Southeast States. State by state, the percentage rejected ranged from 1/2 per cent to 14 per cent.¹ Because of the cultural bias in conventional intelligence tests, the real intellectual potential of this group, as well as its level of functioning outside the test situation, cannot be assumed to have been adequately assessed.

Patients of the first two groups, the moderately, severely and profoundly retarded, are proportionally distributed among all socio-economic strata, and patients of the last group, the mildly retarded, are mostly from the deprived socio-economic class.³ How much the inadequate nutrition of the pregnant mother and of the nursing infant contribute to further exaggeration of mental retardation is yet unanswered. Other unanswered questions are many: such as, the importance of intellectual stimulation, sometimes called the "intellectual vitamins"; the effect of social demand on academic performance, such as high school authorities expecting all their graduates to be accepted into colleges and universities; the effect of standard job requirements such as the industries requiring high school graduates even for unskilled labor. One can thus see that mental retardation is a complex problem—educational, medical and socio-cultural. No one discipline has answers to all the questions.

Within the past decade radical changes are occurring in the existing institutions for the treatment, care, and training of the mentally retarded persons and people working in the field are presenting new ideas and suggestions.⁴⁻⁸ The consensus favors the rearing of mentally retarded infants and young children of all degrees of retardation in their natural homes if at all possible in order to facilitate the development of a realistically oriented mother-child relationship, which is so important and necessary for the child to desire to live, to grow, and to

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develop. This early mother-child relationship will be beneficial only if it is mature and devoid of rejection, over-protection, or other emotional distortion. Only after the establishment of this mother-child relationship, is the child ready for training and teaching.

Psychiatrists generally believe that no child should be separated from his family if the only purpose is to avail him of some educational or training program and that the proper orientation of a state residential institution is to assist the patient in achieving maximal social, emotional, and intellectual maturation in order to return him to his own home at the earliest possible moment.⁹ It is also generally agreed that a retarded individual should receive the necessary encouragement, assistance, and training to develop to the fullest whatever talent and capability he possesses. It is desirable even for a severely retarded individual to be able realistically to contribute what little he can in a sheltered situation. There are situations where even the most understanding mother may find it difficult emotionally to adjust to a severely mental defective child with multiple physical and psychological handicaps. The treatment and training of a retarded child often involve counselling and sometimes even treatment of the patient's parents.

The basic philosophy of providing all the necessary services to the mentally retarded individuals close by his own community gave birth to the idea of regional centers, which attempts to solve problems arising from a very complex situation requiring the coordinated effort of the various disciplines.

For every half a million population, there should be a regional center. This, of course, varies with the population density. In the greater Cleveland Metropolis there should ideally be four regional centers. It may be estimated that in a population of 500,000, there will be 15,000 retarded persons, with about 200 severely and profoundly retarded, 800 moderately retarded, and 14,000 mildly retarded. The center should be headed by an administrator, preferably a neuropsychiatrist, or psychiatrically oriented pediatrician, trained to recognize and emphasize both the somatic and psychologic aspects of mental retardation and experienced in leading, coordinating, and guiding a team of experts in various disciplines. He should be supported by a staff of medical specialists, clinical psychologists, psychiatric social workers, activity therapists, teachers, nurses, etc.

I. Diagnostic Evaluation Service:

When a child is discovered to be "retarded," whether this is recognized by the obstetrician at the time of the birth or by a pediatrician in early infancy and childhood, by a friend, a relative, or school teacher, the parents can take the child to the center for a diagnostic evaluation without any legal

procedure. This will enable the parents of a "retarded child" to obtain as much information and support as possible at the earliest possible time in the development of the child. This evaluation should be done in an outpatient setting with several (six to eight) visits during which time the total child—his physique, his intellectual potential, his emotional state, and very importantly his environment including his nuclear family, enlarged family, and even his community—should be carefully studied. Of course, not all the 15,000 retarded persons will need such evaluation, since the greatest majority of the 14,000 mildly retarded are recognized and properly placed in special classes for the slow learners in the public school system.

It is estimated that one child of every 1,000 births will be severely or profoundly retarded and that three children of every 1,000 births will be moderately retarded. With a population of 500,000 and a crude birth rate of say 25, there will be 12,500 children born each year of which number 50 will be moderately to profoundly retarded children. If 1 per cent of the mildly retarded children (140 children) requires evaluation for various domestic or socio-economic reasons, the center will have an annual load of about 200 children for diagnostic evaluation.

Following a thoroughgoing diagnostic evaluation, the center should provide the following services:

II. Home Visiting Nurse Service:

The 50 moderately to profoundly retarded children born each year often present multiple medical complications, which make the nursing problem more complicated than most mothers are able to handle without professional assistance: such as, the special feeding technique for a child who does not suck, chew, or swallow normally, the bathing of a spastic or a hypotonic child, the care of an epileptic child, etc. These children require more from their mothers—the warm, loving, accepting, understanding care, and the mothers need advice and support to enable them to provide this tender loving care. An experienced public health nurse can supervise this section of service. Although a number of these profoundly retarded children usually die early, a significant number will be kept alive with the improvement in modern medical science. The center could be expected to provide such service to 200 to 300 children, since a considerable number will certainly be under private medical care.

III. Outpatient Treatment and Training Services:

The Center should have an outpatient department providing medical service and training facilities for those children who are not eligible for either the county operated classes for the trainable retarded children or the public school system operated classes for the educable retarded children. The same depart-

ment should set up standards for such preschool or pre-nursery facilities which are operated by the local, private, or voluntary organizations and should provide consultative service to these facilities. It should also be the responsibility of the same department to encourage the organization of such pre-nursery facilities by the local communities. This department has the responsibility of forecasting, planning, organizing, conducting, and evaluating all treatment and training services, which are not related to school placement and can be provided in an outpatient setting.

IV. *Hospital Intensive Treatment Service:*

The center should have a 300 to 400 bed hospital for (1) the continual observation of multiple physically handicapped, retarded children in order to obtain a more adequate evaluation of their potentials, (2) the intensive treatment of physical handicaps such as orthopedic corrective treatment, (3) the intensive treatment of emotionally handicapped, retarded children, and (4) the 24-hour care of retarded children, who are faced with socio-economic emergency such as when the patient's mother becomes acutely ill requiring hospitalization. This hospital unit must not be confused with a residential care facility. A definite therapeutic goal determines admission and every effort must be made to reach this goal and then return the patient to the community.

V. *The Long-Term Care Service:*

The center should have a 200 bed "nursing home." This is strictly a special nursing home for patients who have received the benefit of intensive treatment and are unable to make further progress. This is not to replace the patients' natural homes or private nursing homes but only to supplement where there is nothing available. The same department should have regular training classes for operators of private nursing homes. When a patient in the nursing home unit develops an acute medical problem, he should be immediately admitted to the hospital unit for intensive treatment without any red tape.

VI. *Sheltered Workshop Service:*

The center should have a sheltered workshop to provide work experience for the adult mentally retarded individual. This workshop should work very closely with the Bureau of Vocational Rehabilitation, so that "graduates" from this workshop may be accepted for further training in the Vocational Rehabilitation Units and eventually may be returned to the community. The same department should serve as a model and give consultative service to the halfway house in the community. Small dormitories should be attached to this unit to serve as a model for the halfway house or group living home, somewhat along the pattern of fraternity house with a house-mother.

VII. *Recreational Service:*

The center should have a separate recreational department. This department will operate playground for small and teen-age children. This playground should be available to "normally intelligent" as well as "retarded" children with the hope of averting the traditional segregation of the "retarded" children. Through playing together in early childhood, they may learn to accept each other. This department will also operate a recreational center providing wholesome recreation and hobby: such as, stamp clubs, choral groups, sewing clubs, etc. Again, this is to serve as a model for the local community, which hopefully will establish small clubs of similar nature closer to the halfway house or group living homes.

VIII. *Research and Statistics:*

The center should have a research department with a biostatistic division. Every patient seen at the Center should have a chronologically arranged longitudinal record. This will provide us insight into what is the real need of a retarded individual and how can the need be met most efficiently and effectively. The same department may, with special grants or affiliations with teaching institutes of high learning, investigate (1) the etiology of mental retardation, (2) the prevention of mental retardation, and (3) the improvement in the diagnostic tools and in the treatment and training modalities.

In the past 50 years the medical profession has not been much involved with the treatment and training of the mentally retarded persons in state schools and hospitals, although the first schools were established by physicians. Psychologists and educationists have contributed a great deal in the training and teaching of the mentally retarded persons. Now they are doing this on a larger scale in the community. This results in a significant change in the population of the state schools and hospitals. More and more younger mentally retarded persons with multiple physical and emotional handicaps are being admitted to state institutions. This is a challenge that the medical profession has to face.

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Bilateral Anterior Tibial Syndrome

Report of a Case

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SINCE Vogt reported the first case of anterior tibial syndrome in 1943, less than 60 cases have been reported. The majority of these cases have been unilateral. Sweeney and O'Brien⁵ reported the fourth case of bilateral anterior tibial syndrome in 1965.

Report of a Case

A 44-year-old white man was admitted to the Veterans Administration Hospital, Brecksville, Ohio on April 6, 1965. His diagnosis was schizophrenic reaction, and he had a history of pacing and drinking water frequently. On May 1, 1965, the patient was transferred to the surgical service because of vomiting, abdominal distention, and pain in both lower extremities. The patient was noted to be anxious; sweating was profuse; the chest was clear to auscultation; radial pulse was 120 beats per minute and regular; blood pressure was 150/80; the abdomen was moderately distended; bowel sounds were normal; tenderness was not elicited to palpation; the bladder was palpable; rectal examination revealed no abnormalities, and the lower extremities were normal in appearance.

Due to the patient's incessant complaint of pain above both ankles, a more careful examination of both lower extremities was performed. No abnormalities in size, color changes, or temperature were noted. Pulses (popliteal, posterior tibial, and dorsal pedis) were easily palpable bilaterally. Knee jerks and ankle jerks were equal in both legs. An increase in tibial pain was noted on extension of the feet (reverse Homans' sign). A marked discrepancy was noted between the subjective complaints and the objective findings.

A Levin tube was placed in the stomach and 720 ml. of watery, coffee-ground fluid was aspirated. On catheterization 750 ml. of urine was drained from the bladder. A rapid drip of urine was noted, and 6875 ml. of urine output was recorded the first day. The specific gravity of the urine was 1.001. Other laboratory data: white blood cell count 16,720, hematocrit 40 per cent, blood urea nitrogen 22 mg. per 100 ml., CO₂ 21 mEq. per liter, chloride 101 mEq. per liter, sodium 136 mEq. per liter, and potassium 3.9 mEq. per liter.

The abdominal signs and symptoms subsided rapidly. Pain above both ankles persisted. On May 3, 1965, swelling, redness, heat, and firmness were noted over both anterior tibial areas. Roentgenograms of both lower extremities revealed soft tissue swelling. The specific gravity of the urine was 1.015. The blood chloride was 98 mEq. per liter and sodium was 133 mEq. per liter.

On May 5, 1965, a biopsy of the right anterior tibial muscle was performed. The tissues were edematous, and dark venous blood oozed from the wound. The anterior tibialis appeared pale brown in color—suggesting a liver-like appearance. The tissue diagnosis was acute degenerative myositis.

Other significant data: On May 14, 1965, the lactic acid dehydrogenase was 990 units. Oscillometric readings on

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May 27, 1965, were above normal. Electromyography performed on June 1, 1965, was compatible with the anterior tibial syndrome. The inflammatory reaction of both lower extremities subsided in eight weeks.

Management consisted of bed rest, elevation of the lower extremities, and antibiotics. Fasciotomies were not performed. The patient was uncooperative, and he ambulated periodically throughout the course of his illness.

The patient was readmitted on March 30, 1966. At this time there were no complaints regarding his lower extremities, and he walked without difficulty. Good pulses were noted except the right dorsal pedis pulse was not palpable. Decreased sensation to touch was noted over the right great toe. No significant disability appeared to have resulted from the patient's illness.

Diagnosis

Reszel et al.¹⁰ state that the initial discomfort in the anterior tibial syndrome is often overlooked. Early clinical impressions are usually cellulitis, thrombophlebitis, shin-splints, muscle strain, or herniation of muscle. Pain may be acute or chronic, may vary in severity, and usually is associated with exercise. Sweeney and O'Brien's⁵ patient had a history of mild anterior tibial pain on exertion for over one year. Two cases of anterior tibial pain reported by French and Price¹ had exertional pain for three and five years. Pain may become more severe with rest. Blandy and Fuller²⁰ postulated the increase in pain was due to a decreased blood flow (with rest) and the lack of pumping action of the muscles. In the cases of chronic anterior tibial pain reported by French and Price,¹ it was thought that the pain was ischemic in origin. Movement of the foot increased the pain. In our case, extension of the foot (reverse Homans' sign) was particularly significant.

Examination may reveal the anterior tibial compartment to be tender, firm, and hard. Bulges over the anterior tibial area may be noted. French and Price¹

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aspirated the bulges found in their cases to rule out varices. Blood was not obtained with aspiration. They concluded the bulges were localized swelling of muscle. As the pathologic process progresses, one may note edema, redness (rash), and an increase in heat over the anterior tibial compartment.

Pulses in the lower extremity may be normal, increased, or decreased. Most cases of the functional type that were reviewed reported increased pulsations and oscillometric readings. French and Price¹ state that the increased pulsations are due to increased tissue pressure and that maximal pulsations are noted when the compression pressure is equal to diastolic blood pressure. Arteriograms performed in the functional cases of anterior tibial syndrome have generally been reported as normal.

Electromyographic studies may reveal normal or varying pathologic changes in the muscle and nerve. Leach et al.⁹ state that electromyography is of no value in acute cases as denervation potentials do not occur for approximately three weeks. They do recommend electromyographic studies as a tool for confirmation, prognosis, and therapy.

Discussion

The anterior tibial syndrome is divided into two categories: functional and vascular. The functional type occurs, usually in young adults, following exertion. Usually no significant arterial disease is demonstrable. The vascular type are cases which are initiated by vascular trauma or occlusion. Blum¹² reported four cases of anterior tibial syndrome in 1957 in which the precipitating cause was acute arterial occlusion: two aortoiliac, one femoral, and one popliteal.

According to Sweeney and O'Brien,⁵ Vogt and others theorized that ischemic necrosis of the anterior tibialis was due to vascular spasm of the anterior tibial artery. Mavor,⁴ however, doubts that vascular spasm could persist for a sufficient period of time to produce necrosis. Edwards⁷ compared the compartment syndrome to ischemic necrosis of the bowel—the flow of blood in the main artery (aorta) is normal while the blood flow in the nutrient artery (superior mesenteric) is reduced or occluded. Reports of normal pulses and arteriograms in the compartment syndrome of the functional type support the view of Edwards.

The principal variation from normal found in the compartment syndrome is increased pressure within the anterior tibial compartment. Anatomically, this compartment has been defined as an unyielding osteofibrous space containing the anterior tibialis, extensor digitorum longus, extensor hallucis longus, the anterior tibial artery, and the deep peroneal nerve. Increased pressure within this compartment would adversely affect its circulation. Indeed, a case of anterior tibial syndrome was reported by Bowden and Gutmann² following a blood transfusion into the compartment at the ankle. French and Price,¹ in their

investigative work, found that pressure within the anterior tibial space increased with exercise in all but two subjects studied. In two cases of chronic anterior tibial pain, they found the pressure rose higher and remained elevated longer than in normal subjects. Wright⁶ demonstrated that during exercise muscle accumulated fluid and gained as much as 20 per cent of its own weight. Bancroft and Kato⁸ also have demonstrated that metabolites caused an increase in muscle weight.

The blood supply to muscle has been studied by several workers. Spalteholz¹¹ showed that the circulation to a muscle was often quite distinct and devoid of significant connections with vessels of neighboring structures. Edwards⁷ states that the anterior tibialis is supplied by nutrient arteries coming from a single main trunk. Lewis¹⁸ has demonstrated that these nutrient vessels may be occluded by pressure which is insufficient to arrest the blood flow in the main artery.

Treatment

Most authorities favor early fasciotomy as the treatment of choice in anterior tibial syndrome. Others favor conservative therapy unless signs of neuromuscular deficit develop. The belief that early irreversible changes occur, the hazard of infection associated with surgery, and systemic illnesses are cited as reasons against performing fasciotomy. The delay in diagnosis and the inability to predict the degree of subsequent injury are also factors that may mitigate against fasciotomy. However, the problem of treatment appears to be similar to an extremity which is encased too tightly in a cast, and Hughes¹⁹ has described changes in the anterior tibial syndrome as being similar to Volkmann's ischemic necrosis. Leach et al.¹³ Mozes et al.,¹⁴ Blandy and Fuller,²⁰ and others have reported clinical improvement and cures by decompression of the anterior tibial compartment. Recovery following decompression six days after the onset of the syndrome has been reported by Horn.³

When the syndrome is preceded by an acute vascular occlusion, Mozes et al.¹⁴ recommend fasciotomy in conjunction with vascular surgery. Eiseman¹⁵ also suggests fasciotomy below an area of wounding where proximal vascular compromise had existed or where a tourniquet has been in place for a protracted period to prevent the possibility of developing compartmental muscular atrophy. The chronic form of anterior tibial pain due to exertion has been cured by elective fasciotomy.^{1, 4}

The dread of infection and poor wound healing has been a major deterrent to employing fasciotomies in cases of anterior tibial syndrome. These complications would appear to be obviated by using the technique for fasciotomy as described by Mozes et al.,¹⁴ and subsequently by Rosato et al.²¹ The principal feature of this technique being the use of a special

fasciotomy through a very small skin incision placed at the upper border of the anterior tibial compartment. Other forms of therapy have not been dramatic or efficacious.

Summary

A case of bilateral anterior tibial syndrome of the functional type is presented. The precipitating factors appeared to be excessive intake of water and pacing. A review of the literature indicates that some people develop unusually high and prolonged pressure in their anterior tibial compartments with exercise. Some people with acute vascular occlusion to the lower extremity will also develop the anterior tibial syndrome. The increased pressure may produce muscular ischemia without occluding the main artery. The ischemia may manifest itself by pain, soft tissue changes, and neuromuscular deficit. In susceptible people who sustain acute vascular occlusions, the impaired circulation, the accumulation of metabolites, and the rigid compartment would explain the occurrence of this syndrome. Blum¹² has suggested a close relationship in the pathogenesis of the functional and vascular-types of this syndrome. French and Price¹ have suggested that shin splints, fresher's leg, and the anterior tibial syndrome with necrosis are but degrees of the same pathologic process. The treatment of choice is decompression of the anterior tibial compartment.

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FROM PIGS TO HUMANS. — Ten cases of canicola fever occurred in Glasgow and district during the seven-year period 1957-63. The source of infection was pigs, with which the patients had intimate contact during the course of their employment. Infection in pigs has been established serologically in eight pig farms. In three of the five farms where human infection occurred *Leptospira canicola* was cultured from the kidneys of pigs slaughtered for human consumption. In one farm the organism was recovered from the kidney of a brown rat killed on the premises. In relation to another farm, motile leptospirae have been observed microscopically in the effluent from a near-by pond.

Of eight contacts investigated one, the wife of the owner of Farm A, showed serum agglutinins against *L. canicola*, sufficient to confirm a previous infection.

The clinical picture was typical, with headache, meningitis, and a characteristic suffusion of the conjunctivae forming a diagnostic triad. In one patient the illness was complicated by iridocyclitis.

It is suggested that canicola fever is an occupational disease among piggery workers. The recovery of live *L. canicola* from pig kidneys post mortem points to a hazard to persons other than those employed in occupations at risk. — James H. Lawson, M. D., D. P. H., and S. W. Michna, Ph. D., M. R. C. V. S., Glasgow: *British Medical Journal*, 2:336-340, August 6, 1966.

Acute Polymyositis

Report of a Case in a Child

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DERMATOMYOSITIS is a generalized disease, occasionally involving many organs of the body, but characterized primarily by non-suppurative inflammation of the striated musculature and usually accompanied by cutaneous lesions. In rare cases the cutaneous lesions are absent. Then, the disease should more properly be termed polymyositis. Dermatomyositis probably belongs in the same group of diseases as scleroderma, sclerodactyly, myositis fibrosa, and calcinosis universalis. This appears to be

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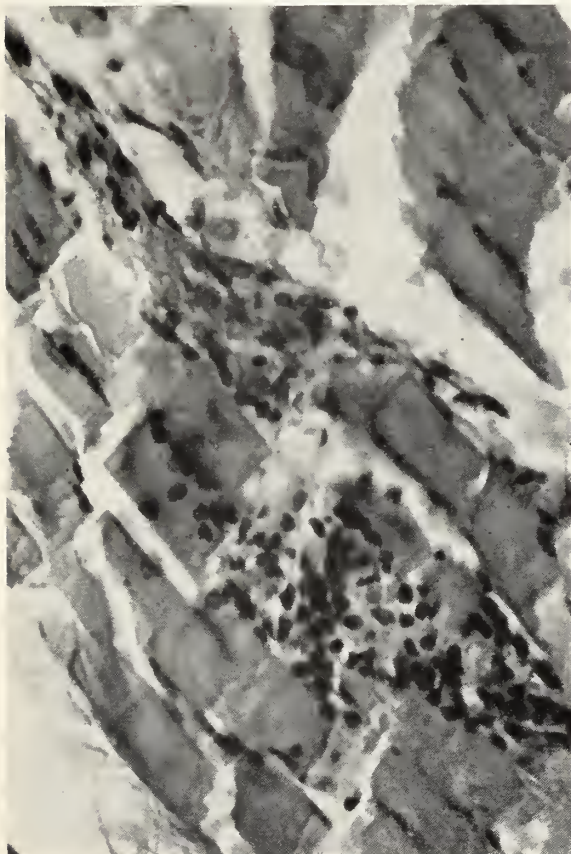


FIG. 1. TRICEPS Muscle fiber replaced by necrotic debris in part. Also note inflammatory infiltrate adjacent to it.

one of the group of collagen diseases of unknown etiology, probably related to some undefined immunological reaction.¹

The onset is usually insidious but may be acute. The most common early symptoms are muscle weakness and easy fatigability. Muscle stiffness, soreness, and a peculiar brawny induration are common. The clinical course is variable, ranging from rapid progression and early death to a protracted course of several years. There is about a 40 per cent mortality rate. The most critical factor, in respect to survival, is the degree of involvement of the muscles of respiration and deglutition. Deposits of calcium, apparently secondary to the necrosis, are found late in the disease. When extensive, this secondary condition has been included in the syndrome of calcinosis universalis. In patients who survive, the major factor contributing to disability is residual contracture of extremities. In most cases, exacerbations do not occur once the disease process has become quiescent. The only diagnostic laboratory procedure is a muscle biopsy.² Treatment consists mainly of symptomatic measures and the use of physiotherapy to minimize contractures. Steroid therapy offers symptomatic relief but probably does not alter the course of the disease.³

Case Report

A white girl, born February 4, 1953, was first admitted to Barberton Citizen's Hospital in October, 1959 at the age of 6½ years. She gave a three to four day history of stiffness and soreness of the fingers and hands. This progressed rather rapidly to include difficulty in the use of her wrists, elbows, and ankles, and difficulty in walking. There had been no antecedent upper respiratory infection or sore throat. There was no fever or difficulty in breathing or swallowing. There was no swelling or redness of any

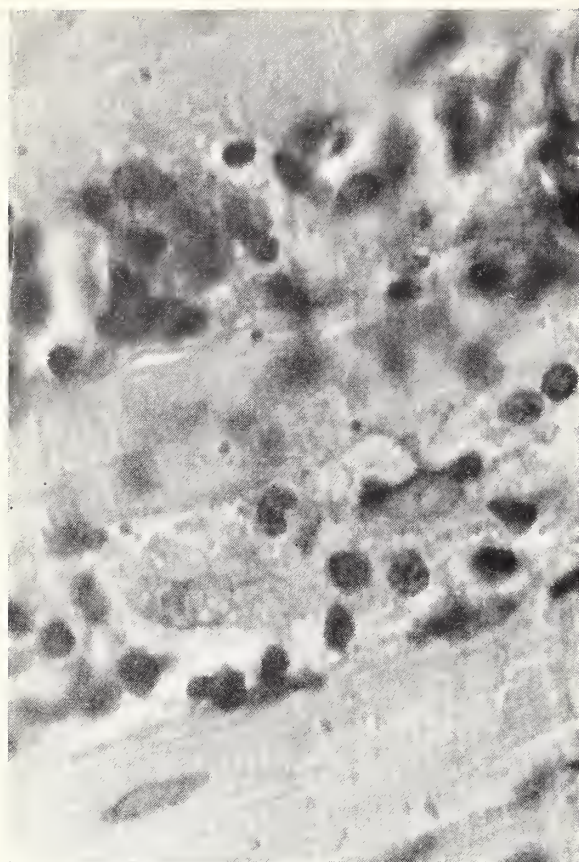


FIG. 2. *TRICEPS* Coagulation necrosis of muscle fiber with two adjacent fibers relatively uninvolved. Usual cellular infiltrate present.

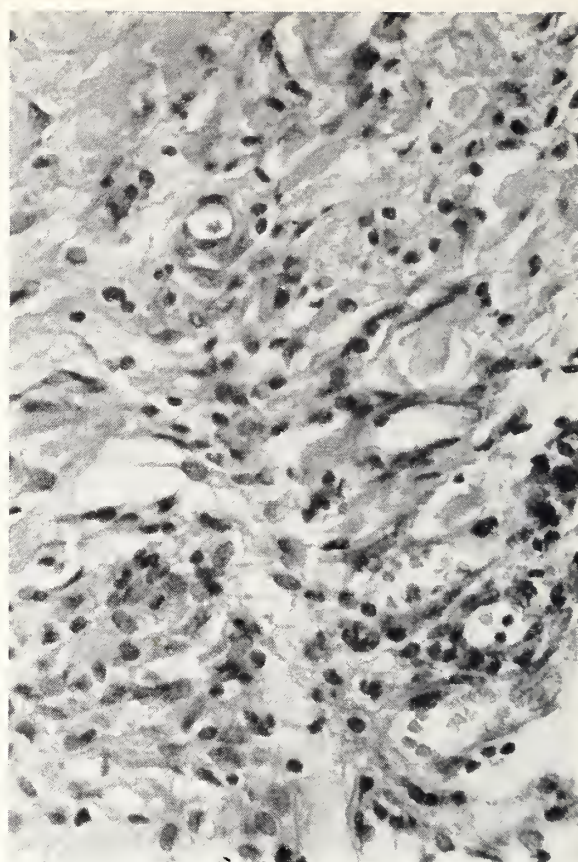


FIG. 3. *DELTOID* Necrotic muscle fragments and inflammatory infiltrate. Perivascularitis also noted.

joints. The past history and family history were noncontributory. Examination on admission was entirely negative except for the obvious difficulty in movement of the fingers, hands, wrists, elbows, and ankles. In addition, there was a definite firmness or woody induration of all of the extremity muscles. There was no involvement of the skin. There were no demonstrable sensory changes. The fundi were normal. She was afebrile and all vital signs were normal.

A throat culture was negative for pathogens. Urinalysis, serum calcium, uric acid, antistreptolysin titer, rheumatoid factor, C-reactive protein, stools for ova and parasites, and electrocardiogram were all normal. Serum protein electrophoresis was normal. Tests for serum aldolase, glutamic oxalacetic transaminase, lactic dehydrogenase, and creatine phosphokinase were not available and were not performed. The blood count was normal except for a 24 per cent eosinophilia. The sedimentation rate was 28 mm per hour. Skin tests for tuberculosis and trichinosis were negative. X-rays of the chest and upper extremities were negative. X-rays of the lower extremities were negative except for "non-visualization of the fascial planes." No soft tissue calcifications were noted. A barium swallow revealed a normal appearing esophagus.

Orthopedic and neurologic consultations were negative except for the "woody firmness of all extremity muscles." Muscle biopsies from the gastrocnemius, deltoid, and triceps muscles were reported as "Sections of striated muscle reveal a similar picture in which the striated muscle bundles are, for the most part, atrophic. There are many areas demonstrated in which the muscle strands have been replaced by collagenous fibrous tissue elements, which infiltrate the interstices as well as replace the muscle bundles. The interstices throughout show lymphocytic cell infiltrates which are most prominent about the blood vessels.

Diagnosis: "Acute polymyositis." (Figs. 1, 2, 3.) She was seen briefly by Dr. Albert Dorfman, Professor of Pediatrics, University of Chicago, who concurred in the diagnosis.

The eosinophilia persisted, varying from 31 per cent shortly after admission to 1 per cent at the time of discharge. She remained afebrile throughout the hospital course and exhibited no respiratory or swallowing difficulties. She was treated with triamcinolone, 2.0 mg. four times daily, until discharge a month later. She was continued on triamcinolone after discharge for a period of six months. During this time she had a gradual decrease in the joint stiffness and woody induration of the muscles. She was encouraged to be active, and she attended school. Her growth continued normally, and she exhibited no side effects from the steroid therapy.

Two years after the onset of the illness physical examination was entirely negative. Chest x-ray, blood count, urinalysis, sedimentation rate, and C-reactive protein were all normal. There was no eosinophilia. The electrocardiogram was normal. She has continued to lead a normal life, attending school without physical difficulties six and one-half years after initial onset of polymyositis.

Discussion

Although the incidence of dermatomyositis in children is relatively rare, the occurrence of acute polymyositis (without cutaneous involvement) is considered even less common. Progression of the disease process is quite variable, although 40 per cent terminate in death within two to three years of onset. Death is usually from respiratory failure,

dysphagia or ulceration of the gastrointestinal tract.³ Of those that survive, muscle contractures are a common disability. When severe wasting has occurred calcium deposits in the muscles are common. This may be extensive enough to be diagnosed as calcinosis universalis.

The diagnosis in this patient would appear to be relatively certain because of the physical findings and the muscle biopsy confirmation. Other forms of collagen disease were ruled out. Her apparent complete recovery without residual deformities may have occurred spontaneously, but it is felt that the use of steroid therapy enhanced this.

Summary

A 6½ year old girl was first seen with a history of muscle pain and stiffness of short duration. The

main feature on physical examination was a brawny induration of all extremity muscle groups, associated with pain and limitation of movement. There was no evidence of cutaneous involvement. Eosinophilia was present. Muscle biopsies revealed diffuse myositis and perivascularitis. A diagnosis of acute polymyositis was made. Treatment with triamcinolone gave slow but eventually complete remission of symptoms. Six and one-half years after onset she is leading a normal life with no evidence of relapse or residual deformity.

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NORMALLY HEALTHY CHILDREN should not be vaccinated against influenza, despite current predictions of increased outbreaks of A2 influenza during the 1967-68 season. Only children who may suffer severe complications from the virus should receive flu vaccine.

These recommendations by the American Academy of Pediatrics are based on evidence that currently-available influenza vaccines cause feverish or other types of reactions among many children who are vaccinated. The statement recommends influenza immunization only for "children known to experience high morbidity or mortality from influenza," including children with these conditions:

- Rheumatic heart disease, especially those with mitral stenosis.
- Other cardiovascular disorders such as congenital or hypersensitive heart disease, especially fully-developed or beginning cardiac insufficiency with easy fatigue or shortness of breath.
- Chronic bronchopulmonary diseases including cystic fibrosis of the pancreas, chronic asthma, chronic bronchitis, bronchiectasis, pulmonary tuberculosis, and patients having weak or paralyzed respiratory muscles.
- Chronic metabolic disease.
- Chronic glomerulonephritis or nephrosis.
- Chronic neurologic disorders.

The Academy further recommends that the comparatively new bivalent vaccine be administered to immunize those infants and children who require protection this year. Children who have never been vaccinated, or who have not been vaccinated since 1963, should receive a primary influenza immunization series consisting of an initial injection of bivalent vaccine, followed by a second injection two months later. Children vaccinated after July 1963 require only a single bivalent vaccine booster.

Discussing amantadine, a drug for preventing influenza, the Committee on Control of Infectious Diseases recommends that it not be used for children. The statement emphasizes that the drug has not been widely studied in children; its effectiveness is reportedly limited to influenza A2 virus infections; specific virus diagnosis "in anticipation of exposure" is impractical, and the drug has caused toxic reactions when administered in dosages of only 100 to 200 milligrams above recommended amounts.

Peripheral Vascular Disease

I. Diagnosis of Chronic Occlusive Arterial Disease of the Extremities

RAY W. GIFFORD, Jr., M.D.

THE CAUSE of more than 95 per cent of cases of chronic occlusive arterial disease of the extremities is atherosclerosis obliterans (ASO). Next in frequency is thromboangiitis obliterans (TAO) or Buerger's disease. Less common causes include arterial trauma, embolic occlusion when the extremity survives the acute episode, idiopathic thrombosis, and Takayasu's arteritis.

The predominant symptoms of chronic occlusive arterial disease are those of ischemia, and are similar regardless of the underlying etiology. Coldness of extremities, especially when it is only subjective and symmetric, numbness and paresthesias of extremities, and nocturnal leg cramps are usually *not* symptoms of ischemia, though they are frequently misinterpreted as such. The first manifestation of ischemia in the lower extremities is usually *intermittent claudication* which is characterized by discomfort (often not described as pain) or weakness that appears only when the victim is walking, and disappears within five minutes after he stops walking, whether or not he sits down. Depending on the site of the occlusive disease, intermittent claudication can occur in the muscles of the arch of the foot, the calf, thigh, buttock, or in the upper extremity.

The onset of pain in the limb when it is at rest indicates worsening of the ischemia. The pain of *ischemic neuropathy* affects large segments of the limb and occurs paroxysmally in severe, lancinating, shock-like waves. *Pretrophic pain* is a deep, steady, boring discomfort localized to the most severely ischemic digits and adjacent portions of the foot, and heralds the onset of tissue necrosis. The *pain of ulceration and gangrene* is similar, but more severe and is localized to areas of tissue necrosis. All types of rest pain are typically worse at night and are usually relieved by placing the limb in the dependent position.

The most important physical finding is absence or diminution in amplitude of arterial pulsations. The dorsalis pedis pulsation may be absent, owing to anomalies in about 5 per cent of normal individuals. It is perilous to make the diagnosis of chronic occlusive arterial disease when all peripheral pulsations are normal, except in rare instances when the occlusive disease is confined to the small palmar, plantar, or

digital arteries, or when the occlusion is confined to a localized segment of the terminal aorta or iliac artery and the collateral vessels are adequate to provide pulsatile flow to the distal arterial tree. It is only in situations such as these that arteriography is necessary to make the diagnosis of chronic occlusive arterial disease, although it is indispensable to delineate the extent of the disease for the surgeon.

The presence of a systolic bruit over the abdominal aorta, iliac or femoral arteries after the patient has been lying quietly for more than five minutes is indicative of intimal disease, usually atherosclerosis, but does not necessarily indicate that the disease is occlusive. Contrariwise, occlusive disease frequently occurs in the absence of bruits.

The best index of the severity of ischemia is provided by the postural color and venous filling tests. With the patient supine, the feet are elevated for at least 60 seconds, after which their color is observed. The greater the pallor, judged on the basis of 0 (none) to 4 (extreme pallor), the more severe the ischemia. The feet are then placed in the dependent position while the patient is seated on the examining table and the time that elapses until normal color returns to the feet and until the collapsed veins become distended is noted. Normally, color should return within five seconds and when it does not return for more than 10 seconds, the part is definitely ischemic. A delay of more than 20 seconds indicates severe ischemia. The veins on the dorsum of the foot or hand normally refill within 10 seconds after the limb is placed in the dependent position, and if it requires more than 20 seconds for them to become fully distended, ischemia is definite, and if more than 40 seconds, ischemia is severe. *Incompetency of the venous system negates the validity of this test.* The significance of dependent rubor is similar to that of elevation pallor; the greater the rubor of the feet when they are in the dependent position, the greater the ischemia.

Oscillometry, infrared thermography, plethysmography, skin temperature measurements, and the more recently developed electronic devices for measuring blood flow, are not substitutes for physical examination and are not essential to make the diagnosis of chronic occlusive arterial disease. Furthermore, the results of these procedures can be misleading if not interpreted in relation to the findings elicited by the patient's medical history and physical examination.

The Heart Page is a periodic feature of *The Journal* containing brief, practical comments on subjects of immediate importance to practicing physicians. The comments are solicited by the Professional Education Committee of the Ohio State Heart Association.—ED.
From the Division of Medicine, The Cleveland Clinic Foundation, Cleveland, Ohio.

A Clinicopathological Conference

From The Ohio State University Hospital, Columbus, Ohio

Edited Under the Auspices of the Ohio Society of Pathologists

PAUL N. JOLLY, M.D., *President*

PRESENTATION OF CASE

THIS white woman, aged 41 years, had been on oral iron therapy intermittently most of her adult life because of a hemoglobin that was usually 11 to 11.5 Gm. The highest reported hemoglobin was 12.2 Gm. A bilateral partial salpingectomy had been performed following the birth of her fifth child 15 months prior to admission to Ohio State University Hospital. Her final illness began 30 days prior to her admission to University Hospital with the rather sudden onset of fever, chills, burning on urination, and a dull pain in the right upper quadrant of her abdomen. Her physician told her that she had the "flu" and advised aspirin and rest. She failed to improve. She became weak, had a recurrent afternoon and evening fever, intermittent night sweats, and finally was admitted to her local hospital 14 days prior to her admission to University Hospital.

It was learned there that she had had three injections of Imferon® about a week prior to the onset of the chills and fever. The physical examination was reported to have shown no abnormalities except for a palpable liver and spleen. The laboratory studies were reported as follows: white blood cell count 2,800, hemoglobin 11 Gm.; the direct van den Bergh 0.6 mg. per 100 ml., indirect 0.4 mg.; red cell fragility normal; heterophil agglutination positive 1:7 on two occasions (negative in the clinic prior to admission there); febrile agglutinations negative; three lupus erythematosus (LE) cell preparations negative; uroporphyrins negative; prothrombin time normal; thymol turbidity 0.6 units; cephalin flocculation 2 plus in 24 hours and 3 plus in 48 hours; total proteins 7.2 Gm. per 100 ml. (albumin 4.6 Gm.); alkaline phosphatase 16 units; bromsulphalein (BSP) 10 per cent retention in 45 minutes; serum glutamic oxalacetic transaminase (SGOT) 180 units. Skin test with old tuberculin 1:1,000 was negative. Two blood cultures were negative. The chest film showed no abnormalities. An oral cholecystogram showed some concentration in the gallbladder and no stones were outlined. Five days before the patient was transferred to Uni-

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versity Hospital a vesicular rash appeared on the palms of her hands. This subsequently became extremely pruritic. Some of the vesicles coalesced to form bullae which showed some hemorrhage. These were aspirated and cultures were negative.

There was no family history of diabetes, tuberculosis, or cancer. An infected inguinal lymph node had been removed 13 years before her final illness and a breast biopsy had been performed seven years before, without findings of malignancy.

Physical Examination

On admission to University Hospital the patient was well developed and well nourished. The blood pressure was 120/54, pulse rate 128 per minute, respiratory rate 50 per min., temperature 100.5 F. The skin was pale. The sclerae were icteric and the conjunctivae were reddened; the fundi appeared normal. The mouth and tongue were dry. The pharynx was clear. The neck was supple, the thyroid was not enlarged, and there was no cervical lymphadenopathy. The breasts were normal. The heart was not enlarged. There was a grade II/IV apical systolic murmur; no thrill was detected. The lungs were clear to percussion and auscultation. The liver edge was sharp, smooth, and tender and was palpable 4 to 5 fingerbreadths below the right costal margin. The spleen was enlarged and slightly tender, and its smooth round edge was palpated 3 fingerbreadths below the left costal margin. On both palms was an erythematous papular eruption with greenish-brown pigmentation.

Laboratory Studies

The following values were reported for the admission laboratory studies: white blood cell count 2,700 (87 per cent neutrophils, 4 per cent basophils, 2 per

cent lymphocytes, 6 per cent monocytes); red blood cell count 2.46 mil.; reticulocytes 1.8 per cent; platelets 127,920; hemoglobin 8 Gm.; hematocrit 26 per cent; prothrombin time 14 per cent of normal; total bilirubin 8.3 mg. (direct 6.6 mg.); cholesterol 220 mg. per 100 ml. (15 per cent esters); alkaline phosphatase 23.6 units; SGOT 1,200 units; serum glutamic pyruvic transaminase (SGPT) 600 units; serum sodium 136 mEq. per liter, potassium 4.3 mEq., chlorides 103 mEq., CO₂ combining power 27 mEq.; blood urea nitrogen (BUN) 16 mg. per 100 ml., creatinine 1.3 mg. Urinalysis showed a specific gravity of 1.006, protein 20 mg. per 100 ml., 1-3 coarsely granular casts and 2-3 red blood cells per high-power field. The bone marrow examination revealed no abnormalities. Leptospiral, heterophil, and febrile agglutinations were negative.

The electrocardiogram showed incomplete right bundle branch block. The posterior-anterior and left lateral chest x-ray films showed no abnormalities. The abdominal films showed hepatosplenomegaly.

Hospital Course

On the first three hospital days the patient had a spiking afternoon temperature to 104 F. On the third day prednisone was begun (40 mg./day), and she received the first of the 15 units of fresh whole blood and several units of fresh frozen plasma that she eventually received. Her hemoglobin reached 13 Gm. on the 13th hospital day but fell rapidly to 9 Gm. in the next two days. After initial control of her fever with prednisone she again had intermittent afternoon fever spikes to as high as 105 F. She was given Mephyton®, daily multivitamins, Benadryl®, chloral hydrate, and eventually neomycin.

She was noted to have gradually increasing abdominal distention with shifting dullness and an increasing alkaline phosphatase, which reached a peak of 44 units on the eighth hospital day. By the 12th hospital day the jaundice seemed to fade and the stool was somewhat darker. Her abdomen was almost flat. On the 13th hospital day she had a guaiac-positive stool. By the 15th day she was again noted to have increasing jaundice, increasing petechiae, and increasing drowsiness. The protein in her diet was reduced to 30 Gm. per day. The lactic dehydrogenase (LDH) was 1,650 units. By the 18th hospital day she had become lethargic and her abdomen had again become distended with ascites. On the 20th hospital day she began to have black, tarry stools and increasing lethargy.

A liver "flap" developed on the 26th hospital day and that day she had the first generalized convulsion, which lasted five minutes. At that time the total bilirubin was 55 mg. (direct 35 mg.), cholesterol 188 mg. (33 per cent esters), alkaline phosphatase 11.2 units, SGOT 150 units, SGPT 50 units, LDH 2,100 units, fibrinogen 0.176 Gm. per 100 ml., cephalin flocculation negative, total protein 4.2 Gm. (albumin 2.8 Gm.). The BUN had gradually risen to 94 mg.

on this day, with a creatinine of 4.3 mg. More convulsions ensued on the following day, with increased gastrointestinal bleeding, and she became very lethargic. On the 28th hospital day it was noted that her liver had definitely become smaller. On the morning of the 29th hospital day she developed difficulty in breathing and died before a physician could reach her bedside.

CLINICAL DISCUSSION

DR. SASLAW: Apparently, we have a case of severe hepatic disease in a young woman who became comatose within the space of about two months. The thing I think we have to determine is, Did she have underlying disease prior to this episode or did this arise *de novo*? She had been on intermittent oral iron therapy most of her adult life due to a low hemoglobin, and right away you begin to think that you have a patient with lupus and lupoid hepatitis. But as you go further you are not so sure. The most recent thing prior to that is that she had a bilateral salpingectomy 15 months before, and this also would suggest the possibility of underlying disease. One thing that is frequently overlooked is that a woman with repeated pregnancies gets urinary tract infection with bacteriuria. Another possibility for antecedent underlying disease is the story of the breast biopsy seven years ago. There is the statement that no malignancy was found and if one had been present it would have been a pretty long time for the appearance of any metastasis. Thirteen years ago she had an infected lymph node removed and of course we often see what at first looks like infection later develop into lymphoma, but from the protocol we find it pretty hard to find support for that assumption.

Flu-like Onset

One of the things that strikes me as pertinent is that her final illness began 30 days prior to her admission to OSU Hospital with the rather sudden onset of fever, chills—a flu-like onset—but with burning on urination, which makes you think of an acute pyelonephritis. She also had some dull pain in the right upper quadrant. Except for the burning on urination, this could fit in with the influenza-like onset of hepatic disease, and it was diagnosed as flu by a physician, who treated her with aspirin which did not improve her. She started to have weakness and recurrent afternoon and evening fever, night sweats, and then she was admitted to her local hospital. While there it was established that about a week prior to the onset of her chills and fever she had received three shots of Imferon. As you know, Imferon is an iron dextran preparation and it is given to anemic patients who have trouble absorbing oral iron, and there are a lot of pros and cons about its indiscriminate application.

It is interesting that at the time of admission to the hospital she showed a leukopenia with a 2,800 white count, hemoglobin 11 Gm. (which wasn't too bad),

a relatively normal van den Bergh, and normal red blood cell fragility. Heterophil and febrile agglutination tests were negative. Somebody wanted to look at her uroporphyrins and there was nothing there. LE preparations obviously were done, with all of them negative. Prothrombin was normal, thymol turbidity was not too much affected, cephalin flocculation was increased, and proteins were relatively normal. The alkaline phosphatase was moderately elevated, the BSP a little increased, and the SGOT was 180. So there is some laboratory suggestion of early liver disease.

Evidence of Liver Disease

It is well known that the BSP and SGOT are the earliest tests to become positive in hepatic disease. It is a little hard to explain the clear vesicular rash on the palms of her hands that is mentioned in the history. It became pruritic later and some of the vesicles coalesced to form bullae which showed hemorrhage. They cultured these and found nothing, and it may have been a drug eruption, or it can fit with hepatic disease with just this type of distribution. She did have a palpable liver and spleen at that time.

When she was transferred to University Hospital she was definitely icteric, had a low-grade fever, and reddened conjunctivae. When you see reddened conjunctivae you should always consider leptospirosis. The skin was pale. There was cervical adenopathy, which we find frequently in infectious hepatitis if we look for it hard enough. She also had a grade II/IV apical systolic murmur, but she had some anemia and with her higher fever and with no thrill I am more inclined to explain this as a hemic murmur and to consider it not significant for this particular situation. The liver was down 4-5 fingers and had a sharp, smooth, tender edge, and the spleen was also enlarged and tender. The rash at this time was described as being an erythematous papular eruption on both palms, and again we do not know whether this is a manifestation of liver disease. Again we are impressed that she had a leukopenia, a low hemoglobin, and the hematocrit was down.

The urine analysis on admission showed a low specific gravity, some protein, and a few coarsely granular casts with a few red cells. Her bilirubin was elevated, the cholesterol esters were depressed, the alkaline phosphatase was increased, and she had an elevated SGOT and SGPT. Her BUN was only modestly elevated this time and with leptospirosis we expect an early elevation of the BUN. It increased later, but I think that we would expect it to be higher at this stage of the game. The bone marrow was normal.

Persistent Jaundice and Bleeding

On the third hospital day the patient was running fever, so she was started on steroids and was given the first of 15 units of fresh whole blood. She got a lot of blood while she was here and apparently must

have been bleeding right along, which is brought out later in the protocol. She got increasing abdominal distention with shifting dullness as though she was developing ascites. Her alkaline phosphatase reached a peak of 44 units on the eighth day. Then by the 12th day her jaundice seemed to fade and the color of her stools became darker. So this tells us apparently that she must have had light stools before. Later the jaundice started to increase, and here they noticed petechiae and drowsiness. She was showing signs of impending hepatic coma. Apparently this was suspected because they reduced the protein in her diet. Her LDH was elevated. She became lethargic, distended, had tarry stools, liver flap, and died with convulsions.

Importance of History

As I said in my opening statement, I feel that this is a case of severe hepatic disease with hepatic coma. While this seems pretty obvious, we have to ask ourselves, What is it due to? In my experience with the differential diagnosis of hepatic disease, the important deciding factor is really a painstaking history. Had she ever had previous jaundice? If she had had hepatitis before, her chance of getting it again is minimal. Since there is no mention here, we will assume that she had not had hepatitis before. This is especially important in relation to any existing cirrhosis. If people with a smoldering hepatitis are followed long enough, they may go into a cirrhotic picture right under our observation. But again we have nothing to suggest such a course of events.

Other very important information we always want in a patient with jaundice is a really reliable history concerning all drugs she had taken. We have no evidence of hepatotoxic drugs in this case with the possible exception of the Imferon that she got. My limited knowledge of Imferon is that you can get skin eruptions and fevers with this drug, and can produce coma in rats or mice. In fact, that's why it was pulled off the market for a while. But I don't know of any reports that Imferon has caused hepatotoxicity. Of course any drug can be hepatotoxic, but at least on the basis of the available information I don't know of Imferon doing this. We also want to inquire pretty closely about injections. Since she did get an injection of Imferon, you must think about homologous serum jaundice, and we also shouldn't forget that ordinary hepatitis A can be transmitted by injection too, because people will carry the virus in their blood streams early. So it is a possibility that this injection might have caused the infection, or she may have had some other exposure to infectious hepatitis.

Another thing which is frequently overlooked is the history of recent dental work. This may be the occasion for an injection of Novocaine®, which might give a patient homologous serum jaundice. We also must inquire into the alcohol history, but since nothing is mentioned here we assume she had none.

When we are considering liver disease I am always impressed with the abdominal pain that the patients have with liver tumors. This woman's pain was not that marked. In primary liver tumors you have severe pain; it is less severe with metastatic tumors and is very vague in hepatitis. The patients usually have only an uncomfortable aching, dragging feeling in the right upper quadrant, which is also present in cirrhosis. Then we always try to look for peripheral manifestations of liver disease—palmar erythema, distribution of chest and pubic hair, xanthomatous deposits, prominent collateral veins, etc. None of these were noticed in this patient. Then of course we look for icterus, which this patient had. We like to palpate the liver, and her liver was enlarged and tender. The patient also had splenomegaly, which occurs in about 15 to 20 per cent of cases of infectious hepatitis and also can occur in carcinoma. Ascites is another thing that we look for, and she evidently developed ascites. Then we have the lab studies to consider and here we have to select those that we can use and try to interpret them in terms of the clinical picture.

Infectious Hepatitis

I may say that her lab tests are compatible with liver disease and in my experience compatible with infectious hepatitis. We can't prove from any of the studies done that she had an underlying disease, such as lupus or a neoplasm. She had an influenzal type of onset and therefore we feel that it was most likely related to an infectious type of hepatitis, and of course we know that a lot of infections can give you jaundice. Let's consider first leptospiral hepatitis. She did have injected conjunctivae, her BUN was elevated although only terminally, but we have no history of exposure to dogs, cats, rats, cows, pigs, or of swimming in stagnant pools. So I don't think we can say from the protocol that this was leptospiral disease. I think we are most likely dealing with another type of infectious hepatitis.

The acute hepatitis that we see most frequently—where you have anorexia, flu-like symptoms, G.I. complaints, etc., with dark urine, deepening jaundice, and a tender enlarged liver followed by diminution of the pre-icteric symptoms and recovery—wouldn't fit here because this patient didn't recover and hers wasn't a mild disease. On the other hand, I think we can also exclude the severe fulminant type—I mean the type with massive necrosis where the patient dies within ten days. In these cases the jaundice appears very early, deepens very rapidly, the abdominal symptoms are very severe right from the beginning, and the patient goes into coma quickly and dies. Another type is the cholestatic type that has a typical onset of infectious hepatitis, but it gives clinical and laboratory findings more suggestive of biliary obstruction. The clinical diagnosis is extremely difficult and frequently may require biopsy or exploratory laparotomy to get the answer there.

What I think this patient represents is a subacute infectious hepatitis formerly called subacute yellow atrophy. This type is usually progressive with a period of 2 to 12 weeks of liver failure and should be considered if the jaundice lasts longer than two weeks, and if the patient develops ascites, edema, and splenomegaly—all of which this patient had. The splenomegaly is often associated with hypersplenism, which could account for her leukopenia and thrombocytopenia and even in part for the anemia in addition to her bleeding tendency. Ordinarily when we think of infectious hepatitis we think of it as being a disease of younger people, more commonly people under 30 years of age, but as sanitation improves we see people in the older age groups affected, just as was the case with polio. It is particularly interesting that subacute hepatitis has a predilection for women over 40 years of age.

In conclusion, I will say that I feel this woman had an infectious hepatitis of the subacute form. She became comatose and developed an infection which was fatal. Was this actually triggered off by some underlying G.U. infection? We can't tell from the data we have here, but she would be entitled to have pyelonephritis, or she could have organisms coming from the gastrointestinal tract. She also had the complications of severe G.I. bleeding and uremia. Of course we still have to rule out toxic drug hepatitis, but again we have no history for this and I plead ignorance that Imferon can cause this type of thing. We must also rule out LE, which can come in all variations, but we have no evidence to support it. We finally have to rule out tumor and leptospirosis.

CLINICAL DIAGNOSIS

1. Subacute infectious hepatitis.
2. Splenomegaly with hypersplenism.
3. Hepatic coma.
4. Possible terminal septicemia.

PATHOLOGIC DIAGNOSIS

1. Infectious hepatitis with massive liver-cell necrosis.
2. Acute renal papillitis.
3. Cholemic nephrosis.
4. Coagulase-positive staphylococcal septicemia.

DISCUSSION OF PATHOLOGY

DR. VON HAAM: The skin of the body showed extremely severe jaundice and numerous petechiae and ecchymoses measuring up to 10 cm. in diameter. Small hemorrhages were also noted throughout both lungs. The liver weighed 1,840 grams and showed an accentuated lobular structure in a greenish-brown parenchyma. Numerous small parenchymal hemorrhages could be noted. The spleen weighed 300 Gm.; it was very soft and showed irregular areas of necrosis. The esophagus showed an area of ulceration in the distal third, and the stomach contained 300 cc. of coffee-ground material. Blood was also present in the small intestine. There was a large

acute ulcer in the sigmoid. Each kidney weighed over 200 Gm. They were soft and showed a smooth, deep greenish surface with scattered small petechiae. The papillae were whitish-yellow. The brain showed liquefaction necrosis and petechiae in the cortex of both hemispheres and within the corpus callosum.

Microscopic sections of the gastrointestinal tract showed numerous large and smaller ulcers with numerous bacterial and fungal colonies. Sections of the liver showed a classic example of severe sub-acute viral hepatitis. The liver cells showed all stages of ballooning degeneration including complete necrosis with little regeneration. There was marked cholangiolitic and intracellular bile stasis and the typical acidophilic inclusion bodies were present. The kidneys showed marked necrosis of the tubular

epithelium, many bile casts, and marked interstitial edema. There was also marked necrosis of the papillae containing the excretory tubules with numerous bacterial colonies and accumulated bile pigment. The bone marrow was severely depressed and its picture was compatible with the thrombocytopenia present in this patient. Coagulase-positive staphylococci and *Candida* were grown from the blood. The post-mortem blood urea nitrogen was 174 mg. and the creatinine 6.8 mg.

In conclusion then, the patient died from fulminating viral hepatitis with severe bleeding tendency. She contracted, as our clinical discussant so well predicted, a fatal secondary infection leading to septicemia with a coagulase-positive staphylococcus probably originating in the ulcer of the colon.

THE CLINICOPATHOLOGICAL CONFERENCE has been one of the most popular features of our Journal for the past 15 years. It is with much regret that we announce transcripts of the Conferences are no longer available.

Publication began in October 1952 through the cooperation of the Ohio Society of Pathologists, the Professors of Pathology at the three Ohio medical schools, and Dr. Jonathan Forman, then Editor of *The Journal*. Although it had been intended that the three schools would provide conferences for publication in regular monthly rotation, Cincinnati and Western Reserve found it impossible to continue after the first year. Since then, this feature has been supplied exclusively by The Ohio State University Hospitals. Now, the Department of Pathology at O. S. U. has found it necessary to reduce the frequency of the conferences from weekly to monthly and to discontinue preparation of transcripts for publication.

We shall miss the C. P. C. because we feel it has been an excellent educational feature in our Journal. We thank those who have contributed to the conferences through the years, and our special thanks go to the secretarial staff of the Ohio State University Department of Pathology. Most especially, we thank Dr. Emmerich von Haam, who was until recently Chairman of that department and whose energies supported this project for so many years.

THE EDITOR.

Guiding Principles for Obstetric Care*

Recommendations Compiled by Committee on Maternal Health After Extensive Study Approved by Council as Guides to Ohio Physicians

A SET of recommendations, entitled "Guiding Principles for Obstetric Care," which were compiled by the Committee on Maternal Health of the Ohio State Medical Association, were approved first by The Council on September 14, 1957.

In doing so, The Council recommended that the principles be published in *The Journal* so that they would receive widespread publicity among the physicians of Ohio.

These principles have been developed by the Committee on Maternal Health, as a part of its study and evaluation of maternal deaths in Ohio. Originally, they were published about three years after The Maternal Mortality Study began (OSMJ 53:1328-1329, 1957). Several years later two revisions were made. Now, with the expansion of educational facets connected with the Study, it becomes mandatory that "Guiding Principles" be revised to meet modern concepts adopted by The Committee. Hence, this third revision is published:

* * *

Preamble

Adherence to well established and medically accepted principles of obstetrics is the foundation for good maternal health. However, the best of principles can achieve a goal only when applied diligently and intelligently. The Committee on Maternal Health of the Ohio State Medical Association, after extensive analysis and evaluation of maternal mortality data, has prepared and hereby recommends to all members of the medical profession the following principles:

Prenatal Care

Hemoglobin or hematocrit should be recorded at the first visit, and repeated at least in the last eight weeks on all patients. In those requiring treatment for anemia, the test should be repeated.

Blood should be tested for syphilis, for blood grouping and for Rh factors at the first visit. Early in

the third trimester of pregnancy, the blood of the "RH-Neg. patient" should be tested for RH-isoimmunization.

Visits should be required of all patients at least monthly in the first six months, every two weeks during the seventh and eighth month, and every week in the ninth month of pregnancy. In case of complications, especially toxemia, weekly visits should begin earlier. Such patients should be seen two or three times a week or preferably the patient should be hospitalized.

Blood pressure, weight, urinary albumin and sugar should be recorded at every visit. Each re-visit should include abdominal examination for height of the fundus, and auscultation of the fetal heart tones, especially in the last trimester.

At the first visit, a *history* should be obtained regarding previous pregnancies, menstruation (including date of last menstrual period with a carefully estimated date of confinement) and nephritis or any kidney ailment, hypertension, diabetes, scarlet fever, allergies, rheumatic fever or any form of heart disease, transfusions or previous surgery of the vagina or cervix.

The High Risk Patient

The Committee emphasizes the importance of early identification of the *High Risk* obstetric patient, by the physician. In addition to a *history of conditions* listed above, the *High Risk* patient may have had anemia, chronic malnutrition or hemorrhagic disorders. Likewise, The Committee places in this category, the female who is a grand-multipara (para VII or more), who is obese (defined below) or one whose environment is of *low* socio-economic status. The *High Risk* patient should register early in her gestation, and should receive continuous *intensive* care during pregnancy, labor, delivery and the puerperium.

A general physical examination, in addition to pelvic examination, heart, breasts, and abdomen, also should be made carefully. Cytologic tests for genital cancer should be performed.

Estimate of capacity of the pelvis should be made, including at least the diagonal conjugate and a realistic appraisal of the outlet.

* A continuous state-wide Maternal Mortality Study is being conducted in Ohio by the Committee on Maternal Health of the Ohio State Medical Association, in cooperation with the Ohio Department of Health and representatives of the various County Medical Societies. Summaries of some of the cases studied by the Committee, based on anonymous data submitted, are published here from time to time, interspersed with statistical summaries.

Weight During Pregnancy

Numerous sources prescribe different standards for ideal weight, and weight gain during pregnancy of 40 weeks. The Committee, after prolonged study, establishes the following figures as *standards* for use in the Ohio Maternal Mortality Study: (1) Normal average total weight gain during the pregnancy, 15 to 22 lbs., "Ideal" being 20 lbs. for 40 weeks. (2) "Excessive weight gain" is a total of 25 lbs. or more for 40 weeks. (3) "Obesity" or the obese woman, is one who has a weight (without clothing) which is 20 lbs. or more *above* the "desirable weight" established for women by current Height-Weight Charts of the Metropolitan Life Insurance Company, New York City. The Committee associates a definite relationship between excessive weight gain during pregnancy, and subsequent development of toxemias.

Throughout late pregnancy, labor, delivery, and the early postpartum period, all attendants should be constantly alert to the signs and symptoms of developing toxemia. Currently accepted treatment should be started promptly. Severe toxemias should be hospitalized for study and vigorous treatment as soon as they occur.

The patient should receive instructions relative to following a properly balanced diet, adequate exercise and hygiene.

In a patient with pregnancy at term, with the amnion (membranes) ruptured, delivery should be accomplished as soon as practicable.

Intrapartum Care

On Admission to Maternity Hospital:

Qualified personnel should note the length of gestation, temperature, pulse and respirations, blood pressure and fetal heart rate, and should immediately report any abnormality to the attending physician. In active labor, determination of the blood pressure, pulse and fetal heart rate should be repeated at least hourly. Hematocrit should be done and catheterized urine should be examined on admission if clinically indicated.

The activity of labor, presence and amount of bloody show and state of membranes should be recorded and reported to the physician, together with Rh factors and serology data.

The time of last meal or ingested fluid should be called to the attention of the physician.

During Labor:

No street clothes should be worn in the delivery room — caps and masks are mandatory when the perineum is exposed.

Adequate observation by a nurse is necessary. One nurse may attend two or more patients.

A physician should be on the obstetric floor when a delivery is imminent. Medication by barbiturates, narcotics, scopolamine, and adjuvant drugs always re-

quires a physician's order and should be on an individual basis. Use of analgesics should be limited when nursing personnel is not adequate for bedside attendance.

Oxytocic drugs should not be given except on individual order, and then with extreme caution and with a physician in attendance.

No vaginal examination should be made on a patient who is in labor except under sterile conditions.

Rectal or vaginal examination should be made on a patient who is bleeding *only* when prepared for operative intervention both vaginally and abdominally. Blood and/or blood substitute should be available for immediate use.

Precipitate Delivery:

If precipitate delivery threatens, the head should not be held back by any method. Delivery of the head may be controlled by the attendant but never delayed. If controlled precipitate delivery occurs, the blood pressure and pulse should be checked immediately and every five minutes for half an hour, the fundus held, and the patient watched carefully for bleeding from hidden lacerations.

Anesthetic:

An anesthetic may be given only by a qualified person in accordance with the laws of Ohio. A qualified person is a physician or a nurse anesthetist. A nurse anesthetist is a registered nurse who has completed a prescribed course in anesthesia, at a hospital in good standing. She must work under the direction of and in the immediate presence of a licensed physician.

A general anesthetic (inhalation or intravenous type) should never be used if the patient has eaten within the past few hours. The general anesthetic should not be used unless it can be presumed that the patient's stomach is empty. Pituitrin® should not be used if cyclopropane is administered. A spinal or caudal anesthetic should be given only by a physician familiar with the techniques and the problems. He must know how to obtain the proper level of anesthesia, and he must be prepared to treat the complications which may develop.

The anesthetist should be in constant personal attendance throughout the entire obstetrical or surgical procedure and should assist in the patient's care until she has recovered from anesthesia.

If local infiltration or pudendal block anesthesia is administered by the obstetrician, an anesthetist is not required. The obstetrician, however, must observe the patient for signs of toxic reaction to the local anesthetic drug, and be prepared to administer appropriate treatment if an untoward reaction should develop.

Delivery:

The absolute minimum personnel includes obstetrician and circulating nurse, and an anesthetist when a

general anesthetic is used. Added nursing personnel should be within a moment's call for unforeseen emergencies.

Delivery through an incompletely dilated cervix is extremely dangerous. High-forceps delivery should not be attempted. Version and extraction except for the second of twins is fraught with danger. Excessive fundal pressure is considered dangerous.

Consultation or assistance should be sought in cases entailing more difficulty than low-forceps delivery.

Asepsis should be surgically strict. Masks should be worn.

Excessive Crede maneuver is dangerous.

Postpartum Care

The Hazard of Hemorrhage is Highest Now:

Careful visual examination of the cervix, vagina and delivered placenta should be made and manual examination of the uterine cavity should be executed if indicated, without deep anesthesia.

It is imperative that the firmness of the fundus and the extent of bleeding be carefully guarded for the first hour postpartum. (Loss of 500 cc. or more is considered postpartum hemorrhage.)

If bleeding continues, the attending physician should check blood for clotting, start parenteral fluids or the transfusion and call for consultation.

Ample supplies of compatible blood and fibrinogen must be readily available in the hospital, preferably near the delivery floor, 24 hours a day.

The vagina should *never* be packed for bleeding from above.

Routinely, in every patient, postpartum blood pressure, height and firmness of the uterine fundus, quality and quantity of vaginal bleeding should be checked and observations recorded periodically for the first hour postpartum, or longer if the patient has not fully recovered.

"Puerperal Sepsis" is defined as an elevation of the patient's temperature to 100.4° F. (38° C.) on any two days of the first ten of the puerperium, excluding the first 24 hours. Management of "Puerperal Morbidity" includes physical examination; culture of the vagina, uterine cavity, blood and/or urine when indicated; administration of the appropriate antibiotic and/or chemotherapy; effect good uterine drainage and evacuate any abscess formation; early evaluation of thrombophlebitis; and supportive measures, including blood administration, diet, etc.

Before being discharged from the hospital of delivery, the patient should be instructed in matters

of conduct and activity during her intermediate puerperium. These instructions should include the date for her first postpartum "Follow-up" visit. She should also be advised to notify her physician immediately, should signs of chills, fever, "sweats," increased vaginal bleeding, or lower abdominal pain develop.

Follow-up:

During the first postpartum visit, a *history* of the interim events should be followed by a brief general physical evaluation and a pelvic examination (listed above) to included cytologic tests for genital cancer, if indicated. Examination of the breasts is important. Final instructions to the patient should include advice as to the proper diet, exercise and hygiene, as well as a recommendation for future return visits for regular periodic examinations to detect early genital malignancy.

The Committee emphasizes the importance of special management of the *High Risk* patient (defined above). She should be clearly advised of the potential risk of future pregnancies, including expert counselling referable to "family planning." Preferably, the *High Risk* patient should be identified *before* pregnancy begins.

The Committee on Maternal Health has prepared these Guiding Principles after much deliberation and diligent study. They are sound, simple and clear-cut. They are designed for use as a guide in evaluating avoidable factors in the study of maternal deaths, based upon standards of "ideal care." The Committee is of the firm conviction that if these principles are utilized rigorously, there will be an appreciable reduction in maternal mortality and morbidity in Ohio.

Approved by The Council of the Ohio State Medical Association, September 17, 1967.

In drafting and revising these principles the Committee secured helpful ideas and suggestions from the following:

Massachusetts Medical Society Committee on Maternal Welfare: Minimum Standard of Obstetric Care. New England J. Med., 252:739-740, April 28, 1955.

Minimum Standard for Prenatal Care Recommended by Kings County Society Maternal Welfare Committee, Ohio State M. J., 32:762-763, August, 1936.

American College of Obstetrics and Gynecology: Manual of Standards, in Obstetric-Gynecologic Practice, 1965. Chicago, Illinois 60603.

Florida Medical Association: A Ready Reference to Current Obstetric Practice, 1965. Florida State Board of Health, P. O. Box 210, Jacksonville, Florida 32201.

Maternal Welfare Committee, Kansas Medical Society: Obstetric Practice Guide. J. Kansas Med. Soc., 64:450-455 (Oct.) 1963.

THE FIRST INTERNATIONAL CONFERENCE on Prematurity, sponsored by the AMA Committee on Maternal and Child Care, will be held January 11-13, 1968 at Pier 66, Ft. Lauderdale, Florida.



NEWS AND *Organization Section*

Proceedings of The Council...

Report of Matters Discussed and Actions Taken
At Meeting of November 4-5, Held in Columbus

A MEETING of The Council of the Ohio State Medical Association was held in the headquarters office, Columbus, Saturday and Sunday, November 4-5, 1967. Those present on Saturday, November 4, were: All members of The Council except Dr. Frederick T. Merchant, Marion, Councilor of the Third District, and Dr. E. R. Westbrook, Warren, Councilor of the Sixth District. Others attending were: Mr. Wayne E. Stichter, Toledo, OSMA legal counsel; Dr. Robert E. Tschantz, Canton, Chairman of the OSMA-OMI Liaison Committee; Dr. Edmond K. Yantes, Wilmington, President, Ohio Medical Indemnity, Inc.; Dr. H. M. Clodfelter, Columbus, immediate past president of Ohio Medical Indemnity, Inc.; Dr. Dwight L. Becker, Lima, treasurer, Ohio Medical Indemnity, Inc.; and Messrs. Page, Edgar, Gillen, Campbell, and Moore of the OSMA headquarters office.

Those present on Sunday, November 5, were: All members of The Council except Drs. Merchant and Westbrook; Mr. Stichter; Dr. John H. Budd, Cleveland, AMA delegate and chairman of the Ohio delegation; Dr. Tschantz; and Messrs. Page, Edgar, Gillen, Campbell, and Moore of the OSMA headquarters office.

Minutes Approved

The minutes of the meeting of The Council held September 16-17, 1967 were approved by official action.

Membership Statistics

The Executive Secretary reported membership statistics as follows: OSMA membership as of Octo-

ber 31, 1967 was 10,072, compared to a total membership of 10,052 on October 31, 1966. Of the 10,072 members, 8,819 were affiliated with the AMA.

Report of Committee on Redistricting

A progress report of the committee appointed by the President to study the problems of redistricting and reapportionment was presented by Dr. Ivins, chairman of the committee.

Reports of Councilors

The Councilors reported on activities in their respective districts.

OSU College of Medicine

The Council discussed the report given by Dr. Meiling at the September 16, 1967 meeting in which he outlined proposals developed within the Ohio State University College of Medicine for a treatment center which would replace the present emergency room and which would be staffed 24 hours a day, seven days a week, by members of the faculty from the Department of Preventive Medicine and would provide complete medical care to all patients without a "means test." Such facility would be used in the training of medical students in the business aspects as well as the medical aspects of the operation.

Camardese Article

Council approved the mailing by the Ohio State Medical Association to all county medical societies of a newspaper article with regard to Dr. Nino Cam-

ardese, Norwalk, which appeared in the October 11, 1967 *Norwalk Reflector Herald*.

Ohio Medical Indemnity, Inc.

The Council convened in executive session. Before The Council was the report of the OSMA-OMI Liaison Committee meeting held October 18, 1967. The report was tabled by official action of The Council.

A number of communications from physicians and county medical societies concerning OMI operations in various counties were studied by The Council.

Saturday afternoon The Council reconvened in regular session. Dr. Edmond K. Yantes, Wilmington, President of Ohio Medical Indemnity, Inc., reviewed the history of that organization and discussed its current operations. Drs. Dwight L. Becker and H. M. Clodfelter, members of the Ohio Medical Indemnity Board of Directors, also spoke.

Sunday morning The Council, on motion duly made, seconded, and carried, voted to remove from the table the report of the OSMA-OMI Liaison Committee dated October 18, 1967. By official action, The Council amended the report and adopted it as a recommendation to be submitted to the Board of Directors of Ohio Medical Indemnity, Inc., for that board's consideration. The text of the amended report follows:

Amended Report of OSMA-OMI Liaison Committee

"1. It is recommended that the term 'fair and reasonable' in the Ohio Medical Indemnity contracts be considered equivalent to the 'usual, customary and reasonable fee' as established by the OSMA House of Delegates, May 24-28, 1966, and by The Council of the Ohio State Medical Association, March 20, 1966, and that in new contracts or new printings the words 'fair and reasonable' be replaced by 'usual, customary and reasonable' and that the portion of the sentence containing the word 'prevailing' be omitted from the new contracts and new printings.

"In our judgment, a fee is 'reasonable' when it meets the usual and customary criteria or, in the opinion of a duly constituted medical society review committee, is justified under what is considered a complexity of treatment which merits special consideration.

"2. It is recommended that a feasibility study of the independent operation of Ohio Medical Indemnity, Inc., be undertaken and reported to The Council, and that Ohio Medical Indemnity be encouraged to continue the development of an independent sales force.

"3. It is recommended that a mechanism be worked out for the dissemination to county medical

society review committees of information necessary for the proper function of such committees."

Liaison Committee Commended

By official action, The Council adopted the following statement: "The Council endorses and commends the OSMA-OMI Liaison Committee for its activities and urges its continued efforts in behalf of the profession."

American Medical Association

Dr. Budd reported on the progress in the campaign for the election of Dr. Carl A. Lincke, Carrollton, for vice president of the American Medical Association and reported on communications which have been received from a number of states concerning Dr. Lincke's candidacy.

Resolutions

Dr. Budd reviewed the following resolutions which had been submitted by The Council and the Ohio delegation for consideration of the American Medical Association House of Delegates, meeting in Houston, Texas, November 26-29, 1967:

Objectives of Voluntary Health Insurance

WHEREAS, The soundness of the financing mechanisms for health care in this country is being threatened by numerous factors, including the effects of inflation, the increasing wage scale, largely legislatively determined, the rising and frequently artificial demand for services which often outstrips their supply, and the insistence by certain segments of the population on complete insurance coverage for all these services, including first dollar expense, and

WHEREAS, Physicians are concerned with conservation of health care dollars, the equitable distribution of health services and the need to supply necessary services with minimum expenditure; THEREFORE BE IT

RESOLVED, That the American Medical Association, through its Council on Medical Service and its Committee on Prepayment Plans, make a determination of the proper objectives of voluntary health insurance, including the scope of services feasibly covered, the facilities in which they may be rendered, with emphasis on an analysis of the inflationary effect of first dollar coverage on rising hospital and health care costs, as well as an assessment of the salutary effect which participation in payment by the insured may have on costs.

Amendments to Title XIX

PREAMBLE

Title XIX embodies many long-standing policies of the American Medical Association with regard to financing of health care for the needy, the most

important of which is eligibility based on need, determined locally, by state-established standards.

Certain essential features, however, are not included. **THEREFORE BE IT**

RESOLVED, 1. That the medical profession take a strong stand in support of the implementation of those portions of Title XIX which do not conflict with the Code of Medical Ethics and the Nine Principles for Standards of Health Care Programs adopted by this House of Delegates on October 2-3, 1965.

2. That the AMA actively seek changes in federal legislation and/or regulations which are in conflict with these principles.

3. That specific efforts be made to accomplish legislation providing for the right of the physician to bill the patient directly according to the individual physician's usual, customary, and reasonable fee, and the elimination of the vendor payment requirement.

4. That these vitally necessary changes are in keeping with the statement made by the U. S. Department of Health, Education, and Welfare in the Department's February, 1967, "Report to the President on Medical Care Prices," namely: "Charity medicine is being abandoned in favor of new public programs which give needy people the resources to purchase medical care from private physicians and hospitals on the same basis as more affluent citizens."

Presidential Commission on Health Care Resources and Medical Manpower

PREAMBLE

The Council on National Security, with the authorization and approval of the Board of Trustees, undertook through a Draft Study Committee, a detailed study and review of the National Selective Service System as it pertains to the selection of physicians for military service.

The Draft Study Committee Report, approved consecutively by the Council on National Security and the Board of Trustees, was adopted by this House of Delegates.

While certain Federal policy changes recommended have been brought to pass, and some statutory changes are progressing toward enactment, a major recommendation for legislative change remains unaccomplished. **THEREFORE BE IT**

RESOLVED, 1. That the House of Delegates request the Board of Trustees to seek legislation providing for the appointment by the President of the United States, with consent of the Senate, of a medically oriented Commission on Health Resources and Medical Manpower.

2. That this Commission review the deployment of physicians and other health personnel in

all government agencies and in the armed services with a view to assuring properly balanced distribution of health personnel among government agencies, the armed forces, and the civilian population.

3. That the Commission be selected from individuals of outstanding national reputation in the medical and health care fields.

4. That officers and employees of the United States will not be eligible for appointment.

5. That the chairman of the Commission be one of its physician members.

6. That requests for health manpower, submitted by the Secretary of Defense to the Department of Selective Service must be reviewed and approved by the Commission prior to action by the Department of Selective Service.

By official action, The Council adopted a fourth resolution for presentation by the Ohio delegation at the AMA clinical convention, as follows:

Supply of Physicians

WHEREAS, The drain of physicians to Federal government administrative positions and to military requirements of the Vietnam conflict has created serious problems with regard to the supply of physicians for care of the people of the United States, **THEREFORE BE IT**

RESOLVED, That the medical schools of the United States be urged by the American Medical Association to return to an accelerated program of producing medical doctors as was successfully used during World War II.

Nurse Anesthetists

The Council instructed the Executive Secretary to bring to the attention of the Ohio Association of Nurses Anesthetists certain practices of members of that group.

Communications from the American Society of Anesthesiologists, which included "Guidelines to the Ethical Practice of Anesthesiology" and the "Standards for Patient Care in Anesthesiology" were referred to members of The Council for study.

Laboratory Medicine

The minutes of the meeting of the Committee on Laboratory Medicine held October 12, 1967, were presented by Mr. Campbell. The committee submitted with its minutes a proposed draft of a laboratory licensure bill. By official action, The Council voted to present this bill in substance to the Ohio General Assembly at the first opportunity and to encourage its passage. The report of the committee as a whole was accepted.

Government Medical Care Programs

Mr. Edgar presented the minutes of the October 25, 1967, meeting of the Committee on Government

Medical Care Programs. By official action, The Council approved the following portion of the minutes involving a statement of policy on House Bill 12080, Social Security Amendments of 1967:

House Bill 12080

"The subject of discussion at the Subcommittee meeting Tuesday evening, October 17, 1967, at which all Subcommittee members were present, was the House Bill 12080, entitled: 'Social Security Amendments of 1967.'

"The Subcommittee's critique of that bill began with praise. Note was made of what the Committee regards as warranted departures from the less well-received House Bill 5710, quashed this past year. The principal differences are that in 12080 'part C' is out, chiropractors are no longer included and provisions to include disabled persons are absent.

"Other sections of 12080 well received by the Subcommittee were 129 and 130 in which hospital outpatient services are included for payment from part B funds. Section 230, dealing with Title 19, 'Medicaid,' provides that a state may opt to make payment to patients 'with respect to physician's services' under specific circumstances. (If this section passes and becomes law, allowing Ohio to exercise such an option, an obstacle will have been removed from the path of physicians wishing to bill directly under Title 18's option.)

"Other sections of House Bill 12080 came in for less favorable mention by the Subcommittee.

Part B Proposals

"Section 131 (a) proposes an amendment to Public Law 89-97 Section 1833 (a) (1) to add a '(B) . . . ' providing Part B payment in 'amounts equal to . . . 100% of the reasonable charges for . . . radiological or pathological services . . . furnished to an inpatient of a hospital by a physician in the field of radiology or pathology.' Patients of physicians in other categories of practice would presumably continue to be reimbursed only 80% of reasonable charges. In view of the efforts of pathologists, radiologists, and others who might fall under the designation of 'hospital-bound physicians' to avoid being distinguished under the law from their colleagues in medical practice, the Subcommittee recommends maintenance of uniform regulations regarding all physicians, making no special distinctions where payment is concerned.

"The members of the Subcommittee received with mixed feelings Sections 126 (a) to amend Public Law 89-97 Section 1814 (a) by striking out (2) (A) and inserting a new (3) requiring certification' . . . no later than the twentieth day . . . in such cases as may be provided by regula-

tions . . . ' The Subcommittee recognized this amendment as touching the controversial issue of 'certification' and 'recertification' by proposing to replace both by what would amount to 'late certification.' It is still distasteful to physicians in the state of Ohio, in the opinion of members of the Subcommittee, to be cast in the role of referees in patient's financial disputes. The Subcommittee felt that physicians are poorly advised to depart from attending to clinical needs of patients in order to address themselves to patients' financial needs. Physicians should stick to their 'last.' Although the Subcommittee recognized that the proposed amendment was a move in the right direction in removing the objectionable section in Public Law 89-97 requiring certification at the time of hospital admission, the Subcommittee did not feel that the public or the profession would be well-served by surrendering this principle. Therefore, the Subcommittee recommends that the appropriate political agencies be encouraged to continue their good work in the direction already taken in Section 126 (a) by removing completely requirements that the physicians enter statements upon the record addressed to financial arrangements, including modification of Public Law 89-97 Section 1862 (a) (1) as may be appropriate.

"The Subcommittee took issue with Section 133 (a) that stated '. . . physical therapy furnished to an outpatient, in a place of residence used as such outpatient's home, by a hospital or by others under arrangements with them made by such hospital . . . ' could be '. . . under the supervision of such hospitals.' As has been called to the attention of the Parent Committee before by this Subcommittee, physicians and not hospitals practice medicine. The Subcommittee recommends, therefore, that this section be reworked so as to make explicit reference to supervision by a physician of outpatient physical therapy.

"The Subcommittee took note of repeated references in both H. R. 12080 and Public Law 89-97 to exceptions in the case of which payment would not be authorized. These exceptions refer to instances in which there was already provision in governmental programs for payment of bills. It seemed to members of the Subcommittee that this constituted a 'means test' in which only third party 'means' were given regard. By contrast, means available to the patient from his own privately controlled resources were not, for purposes of these laws, regarded as having significance as 'means.' To the Subcommittee this was a slap at private initiative not ordinarily meted out in a society respecting the merit of private enterprise and private initiative. The Subcommittee therefore recommends adding provisions to these laws that will include reference to privately held means as having importance on a par with governmentally

or third-party controlled means as to whether Medicaid or Medicare funds shall be authorized to be paid for physicians' services.

"The Subcommittee recommends the forwarding of these recommendations and their supporting rationale to appropriate congressional committees for their earliest, earnest consideration.

"The Subcommittee applauded, of course, the Section 125 provision that provided for authorization of payment on the basis of itemized bills."

By official action, The Council approved the committee's recommendations that Resolution No. 8 (1967 OSMA Annual Meeting) "Mental Health Centers," be referred to the Committee on Mental Health, and that Resolution No. 10 (1967 OSMA Annual Meeting) "Areawide Health Care Planning" be considered to have been carried out through the publication of "Recommended Policies for Government Health Care Programs," which went to all members and County Medical Society officers, Ohio Congressmen and Senators, key Federal and State agencies, and by Dr. Howard's address at the recently completed Councilor District Conferences for County Medical Society officers and key committee chairmen.

Approval of the minutes also carried with it the approval of the tentative outline for an annual meeting program to be presented in 1968 by the committee. Permission was granted to modify the program. The report as a whole was accepted with commendation.

Standardized Billing Form

The staff was authorized to develop a standardized billing form for Council consideration at the next meeting.

Department of Public Welfare

Mr. Edgar reported that the Ohio Department of Public Welfare and Nationwide Insurance Company both had requested at a meeting October 26 that OSMA send its members information Medicare requires on billing forms in order for payments to be made for professional services.

The ODPW representatives proposed a procedure involving payments on the basis of a promissory note. Mr. Edgar reported that, just prior to The Council meeting, the Department had informed him that the Chicago Regional Office of HEW had rejected the promissory note proposal submitted by the ODPW.

He said that ODPW was informed by the Regional Office that the rejection was because the government would have no assurance that physicians would cancel the promissory note after payment was made by the Department of Public Welfare and might collect twice, once from the Department and once from the patient, for the same service.

The Nationwide Insurance Company's Part B, Medicare, representative, Mr. Edgar reported and

requested that the OSMA publicize the information on bills necessary under Medicare regulations, if payment is to be made.

Council approved a plan whereby an article will be published in *The Ohio State Medical Journal* to illustrate physicians' bills that carry adequate information and bills that carry information inadequate for the payment regulations.

Mr. Edgar also reported that he had been informed by the secretary of a paramedical organization that Washington officials had stated that there was an Aid for the Aged medical fee schedule in Ohio. Mr. Edgar contacted the Washington official in charge of Title 19 medical services administration and was told by that official that he knew of no fee schedule, but he would ask his staff to investigate.

The same official, Mr. Edgar reported, stated that a directive enlarging the responsibility and advisory capacity of state welfare medical advisory committees is to be sent to all state welfare directors in the near future.

Federal Legislation

Mr. Edgar reported that the Senate Finance Committee had completed work on certain sections of H. R. 12080, proposed amendments to Medicare. He reported that generic prescribing, as well as extension of Medicare benefits to the disabled, had been rejected by the committee, but the committee had voted to have a study of a Medicare drug formulary program conducted.

Mr. Edgar also reported that a bill pending in Congress to exempt nonprofit associations from Internal Revenue Service regulations on taxing "nonrelated income" of associations had not made any progress.

1968 Annual Meeting

A report on the 1968 Annual Meeting was presented by Mr. Campbell.

The Council recommended that cash donations not be accepted from exhibitors in lieu of rental of exhibit space at the annual meeting.

It was recommended by The Council that the cost of the tickets for the Gaslight Party be held to \$8.00 a ticket; that the party start at 7 P. M. and the entertainment at 8 P. M.; that there be a cash bar with five cent beer; and that snacks be provided without charge.

The Council requested that a complete program be mailed to all members in advance of the meeting.

Fluoridation

A request for assistance with a program involving statewide mandatory legislation to adjust the fluoride content of public water supplies of Ohio was referred to the Committee on Environmental Health for study.

Abortion Law Reform

Regarding a communication from the Ohio Committee for Abortion Law Reform, the Executive Secretary was instructed to notify that committee that the

Association declines its offer to be listed as a sponsor or to have any of its officers listed as a sponsor of such a committee, since the House of Delegates has mandated the sponsorship of only one particular bill and an association with a broad committee effort is deemed to be inadvisable.

A request for the mailing list of OSMA members was not granted.

Retirement of Mrs. Ruth K. Glaze

Recognizing the retirement of Mrs. Ruth K. Glaze from the OSMJ staff after seventeen years of service, The Council, by official action, commended her for her service and devotion to duty and expressed its best wishes for a long and happy retirement.

Mahoning County Resolution

The Council received a resolution submitted by the Mahoning County Medical Society for introduction at the 1968 Annual Meeting.

There being no further business, The Council adjourned until the next meeting on December 9 and 10, 1967.

Attest: HART F. PAGE,
Executive Secretary.

State Medical Board Staff Member For 24 Years Retires

Miss Evelyn Hall, senior staff member of the State Medical Board of Ohio, and an employee of that agency for some 24 years, retired on October 31.

Under the administration of the late Dr. Herbert M. Platter, and recently under Dr. W. Thomas Washam, Board Executive Secretary, Miss Hall handled much of the detail for examination and licensing of thousands of doctors of medicine and other practitioners under the Medical Practice Act.

Miss Hall who resides at 7 West Southington Avenue, Worthington, plans to catch up on her traveling and perhaps do some part-time work.

An intensive program on "Current Concepts in Cardiology," is being offered by the Institute for Cardiovascular Diseases, at Good Samaritan Hospital, 1033 East McDowell Road, Phoenix, Arizona, and the American College of Cardiology, on January 10, 11, and 12. Meeting place is Del Webb's Towne House, in Phoenix.

**Would You Like a 30 week
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OHIO ACADEMY OF GENERAL PRACTICE

Annual Roundup on Federal, State, and Local Taxes for Physicians

WITH THE END OF ANOTHER YEAR approaching, most taxpayers will be faced with the prospect of filling out reports and paying taxes under several categories of federal, state, and perhaps local laws. This article is presented to furnish at least basic information on tax structures, deadlines for filing, forms to be completed, and potential liability of taxpayers under each classification.

Obviously only general data can be given in an article of this nature. For specific information on individual tax liability, the taxpayer is advised to consult authentic tax manuals, seek the advice of an authorized tax expert, or call upon personnel of the respective taxing agencies. A tax expert can point the way to many advantages under various tax laws as well as guide the taxpayer away from embarrassing errors.

The following tax categories are discussed in this article under respective headings:

(1) Federal Income Tax, including payroll deductions.

(2) The Federal Social Security program, including liability of physicians as employees or as self-employed persons, withholdings from employees' wages, etc.

(3) Ohio Personal Property Tax, including the tax on tangible property used in business and the tax on intangible personal property such as stocks, bonds, investments, cash, and accounts receivable.

(4) Ohio Workmen's Compensation tax, required of those with three or more employees (optional for those with one or two) and the Disabled Workmen's Relief Fund tax.

(5) Ohio Sales and Use Tax.

(6) Ohio and Federal Unemployment Insurance Taxes.

(7) Municipal Payroll Tax, applying to residents of cities or villages which have such tax.

Information in this article is confined to those taxes on which the taxpayer or employer must file periodic returns. It does not include reviews of such taxes as those on real property, for which the taxpayer is billed directly, nor does it include discussion of many excise taxes for which the vendor of goods or serv-

ices is primarily responsible; neither does it include a discussion of licenses.

FEDERAL INCOME TAX

The taxpayer will pay 1967 Federal Income Taxes under provisions of the Internal Revenue Act of 1954, subject to revisions by the Revenue Act of 1962, the Revenue Act of 1964, and certain Treasury Department regulations issued under authority of those provisions. The Social Security Amendments Act of 1965 affects self-employment tax as it pertains to rates.

Who Must File

Every citizen or resident of the United States must file an income tax return if the gross income for the year was \$600 or more for the person under age 65, or \$1200 for the person age 65 or over.

A self-employed person must file a return if his income from self-employment is \$400 or more.

Forms and Payments

There are two types of returns, Form 1040A, and Form 1040.

Form 1040A may be used if the income was less than \$10,000 and consisted entirely of wages reported on Withholding Statements for such wages and not more than \$200 total of other wages, interest, and dividends (excluding \$100 of dividends). When this form is used, if the income was under \$5,000, the Internal Revenue Service will figure the tax and send the taxpayer a bill or refund. If the income was between \$5,000 and \$10,000 the taxpayer must compute his own tax.

Form 1040 is used if the income is less than \$10,000 and the taxpayer must include income from sources not eligible for reporting on Form 1040A; wishes to deduct from wages certain reimbursed expenses, travel, transportation, etc.; or the taxpayer wishes to deduct credits for dividends and retirement income.

Form 1040 must be used if the income was more than \$10,000. Separate schedules, in addition to Form 1040, are provided for reporting business and professional income, capital transactions and other income. They are Schedules C, D and B.

Form 2106 may be used to support travel and transportation expenses.

Declaration of Estimated Tax

Virtually all physicians in private practice, and other persons who have income from sources other than wages subject to withholdings, are required to file declarations of estimated income tax, and to make periodic payments on estimated tax.

Regulations issued under authority of the Social Security Amendments of 1965 require self-employed persons to include their self-employment social security tax in their declaration of estimated tax.

Specifically, every citizen or resident of the U.S. is required to make a declaration if his total estimated tax exceeds his withholdings (if any) by \$40 or more; and

(a) He can reasonably expect gross income exceeding —

(1) \$10,000 for a head of a household or a widow or widower entitled to the special tax rates;

(2) \$5,000 for other single individuals;

(3) \$5,000 for a married individual not entitled to file a joint declaration;

(4) \$5,000 for a married individual entitled to file a joint declaration, and the combined income of both husband and wife can reasonably be expected to exceed \$10,000; or

(b) He can reasonably expect to receive more than \$200 from sources other than wages subject to withholdings.

A single declaration may be made on Form 1040-ES on or before April 15, 1968, for the 1968 taxable year; or, quarterly declarations may be made on or before April 15, June 15, September 15, 1968, and January 15, 1969.

The estimated tax may be paid in full with the declaration on or before April 15, or quarterly on the dates indicated above. For taxable years beginning in 1967, restrictions have been tightened as to allowable errors in reporting estimated tax. The estimate must be within 80 per cent of actual tax to avoid a penalty for most taxpayers. Amended declarations should be filed if the estimated income changes substantially.

Social security self-employment taxes are to be considered in estimating tax liability.

Husband and wife may file separate declarations and a joint final return, or may file a joint declaration and separate final returns.

Exemptions and Allowances

An exemption of \$600 may be claimed by the taxpayer for himself. He may also claim an exemption of \$600 for each dependent of close relationship, or for certain other dependents living in his household. To claim an exemption for a dependent, the taxpayer must have furnished over a half of the actual amount used for the dependent's support in the tax-

able year. Scholarships do not count as income to the child in determining the extent of parental support.

Exemption also is contingent upon the dependent, other than a child, having a net income of less than \$600 for the year. A child may earn \$600 or more and still qualify as a dependent if he is under 19 or a full-time student for five months during the year, or taking on-the-farm training, provided the taxpayer contributes more than half of his support.

An additional personal exemption of \$600 may be claimed by the taxpayer if he is over 65, another if he is blind; another if his spouse is blind; and still another if the spouse has reached the age of 65. (These provisions do not apply to dependents other than spouse.)

Averaging Income

Certain taxpayers who have experienced a substantial increase in income for the year may find it to their advantage to average earnings over a five-year period. Averaging may apply to income from salary, dividends, interest, short-term capital gains, rental income, and business, and professional income. It does not apply to long-term capital gains, gambling winnings, and certain gifts and inheritances. Schedule G is used for income averaging.

Income-Splitting

Most married physicians will find it to their advantage to file joint returns with their wives, whether or not the spouse has income of her own. An unmarried person who qualifies as "head of household" may claim about one-half the tax benefit afforded a married couple on a joint return.

An unmarried widower (or widow) who maintains a home for his dependent children is allowed to use joint return rates in the two years following death of spouse.

Adjusted Gross Income

For the person on salary, the total salary plus amounts received from interest, dividends, rent or from other sources constitutes the gross adjusted income.

The physician in private practice arrives at his adjusted gross income by deducting from cash receipts (or from total charges if he uses accrual method of reporting income) all items of expenditure necessary in earning his income. The more important items are described in the following sections.

Deductible Business Expenses

Office Rent — Rent paid to another person for office space may be deducted. That portion of rent paid for the office in a combined office-home may be deducted on a pro-rata basis of space used. If the physician owns his own home-office combination, he may not deduct rent, but may claim deprecia-

tion on that portion used as an office, again on a pro-rata basis.

Automobile — Cost of an automobile, its repair and upkeep, including gasoline, service, etc., used in professional visits may be deducted. Salary of a chauffeur, sums paid for taxi or other transportation fare, for professional purposes may be deducted.

Depreciation may be deducted on an automobile used in professional business. Annual depreciation may be deducted on the basis of cost, less trade-in value, divided by the number of years the taxpayer uses the vehicle. The physician should seek the advice of a tax expert as to whether the "declining-balance method" of depreciation would be advantageous to him.

If an automobile is used both for professional and family purposes, a proportion of depreciation, cost of upkeep, etc., may be deducted, based primarily on mileage.

Damage to an automobile used in professional work, not done through negligence, and not covered by insurance, is a deductible item.

Under specified conditions the taxpayer may choose to deduct a flat allowance based on mileage accumulation. The allowance, if the taxpayer is eligible, is 10 cents per mile for the first 15,000 miles and 7 cents for additional miles of business travel.

Professional Dues and Publications — Dues paid to professional associations to which the physician belongs, in the interest of his profession, are deductible. Publications purchased in the interest of his professional work become deductible items, as do publications purchased for the waiting room.

Refresher Courses — The Internal Revenue Service makes a distinction between expenses for advanced education and those for refresher courses (Section 1.162-5 of the IRS regulations).

Deductions may be made for "refresher" type courses, or those attended to maintain the skills of the physician and to keep him abreast of developments in his field of practice. Cost of education designed to prepare the practitioner to enter a specialty is not deductible.

Travel Expenses — The Revenue Act of 1962 deals extensively with travel expenses. Emphasis is placed on the distinction between travel time and expenses devoted to business or professional purposes and that used for vacation or entertainment. Regulations are less restrictive for the taxpayers if the trip does not exceed a week or if personal or vacation time does not exceed 25 per cent of the total time of the trip. Expenses for personal activities such as sightseeing, social visiting, personal entertaining or other recreation, are not deductible. A physician who is accompanied by his wife to a medical convention may deduct the amount that the trip would have cost him alone.

Records should indicate a distinction between travel expenses, transportation expenses, and business entertainment expenses while traveling. Meals and lodging may not be deductible if the trip is no longer than a working day or the stay is not overnight.

Entertainment Expenses — Section 4 of the Revenue Act of 1962, or Public Law 87-834, requires the taxpayer to show proof and degree of business relationship for the Federal income tax treatment of certain business travel, gift, and entertainment expenses.

In general, a physician may deduct on his Federal income tax return the costs of entertainment, provided he can establish to the satisfaction of the Internal Revenue Service by appropriate evidence that such expenses are ordinary and necessary business expenses and clearly related to the production of business or professional income.

Exact records on each item are important. Here are criteria that may be used to determine the deductibility of entertainment expenses:

Specific purpose of entertainment; nature of the doctor's practice; period of time in practice; number of patients he already has; percentage of patients received as referrals; names of individuals entertained and reason why additional income could reasonably be expected from each; whether or not referrals were actually received from doctors entertained and any indication of the effect of the entertainment on these referrals; number of times individual doctors were entertained during the year, inasmuch as repeated entertainment indicates a personal motive; whether or not other doctors in the same type of practice in the locality have entertainment expenses.

Depreciation — Important principles in regard to claiming depreciation are contained in Treasury Department Publication No. 456, entitled *Depreciation, Guidelines and Rules*, revised August, 1964.

Depreciation may be claimed on virtually all equipment and furnishings of more or less permanent value used in practice; also on buildings used for business or professional purposes.

If the taxpayer is unfamiliar with methods of claiming depreciation, he may wish to consult a tax expert as to which method would be to his advantage — straight line, declining balance, or sum-of-the-digits method.

Insurance Premiums — Premiums paid for insurance against professional losses are deductible. This includes insurance against damages for alleged malpractice, against liability for injuries to a physician's automobile while in use for professional purposes, and against loss from theft of professional equipment and damage to or loss of professional equipment by fire or otherwise. Premiums paid on life insurance are not deductible.

Premiums paid for disability insurance are deductible only if the policy specifies that benefits are for business or overhead expenses.

Other Business Expenses — Salaries of all persons whose duties are connected with professional work, and the employer's share on Social Security and other payments made in behalf of employees; items consumed-in-the-using such as medicines, bandages, laboratory supplies, etc.; uniforms or other garments used in professional work but not suitable for street wear; cost of telephones, telegrams, heat, light, water, etc.; Ohio and Federal gasoline tax, if this has not been included in cost of gasoline; interest on business indebtedness; cost of replacement or repair of professional equipment lost or damaged by fire, theft, etc., not covered by insurance; certain legal expenses, etc.

Investment Credit

The investment credit for purchase of business equipment was suspended and later restored. In general, the credit is not allowed for equipment acquired during the suspension period, October 10, 1966 to March 9, 1967.

The full 7 per cent credit applies to cost of equipment with a useful life of eight years or more, and a reduced credit for equipment with a useful life of from four to eight years. Taxpayers who feel that this credit is involved in determining their taxes would do well to obtain expert advice. The credit is figured on Form 3468.

Nonbusiness Deductions

Regardless of whether or not the taxpayer claims business expenses, he may claim the following deductions if eligible to do so, providing that there is not a duplication of deductions under the two categories.

Medical, Dental, and Drug Expenses — Several changes were made in regard to medical expense deductions by the Social Security Amendments of 1965, effective beginning in 1967.

(1) Taxpayers 65 years old or older are no longer exempted from the 3 per cent and 1 per cent adjusted gross income limitations.

(2) Maximum ceilings on medical deductions no longer apply.

(3) Fifty per cent of the premium paid for medical care policies, including Medicare Part B payments, are deductible up to \$150. The remaining balance is deductible as ordinary medical care expense.

Deductible items under these headings include the cost of diagnosis, care, mitigation, treatment or prevention of disease, or any treatment that affects a part or function of the body; also costs of transportation primarily for or essential to medical care and cost of travel prescribed for relief of specific ailments; costs of medical and hospital insurance; cost of drugs

whether or not prescribed (but not toiletries and sundries); vitamins and supplements if prescribed. (Cost of special foods and beverages is not deductible as medical expense if taken as substitutes for normal food and drink.)

The taxpayer may deduct under this category for himself, his wife, and his dependents expenses which exceed 3 per cent of adjusted gross income, on condition that the amount of deductions for drugs is in excess of 1 per cent of adjusted gross income.

Deductions may not be claimed for medical expenses reimbursed by insurance.

Contributions, Gifts, etc. — Deductions up to 30 per cent may be claimed for contributions for religious, charitable, scientific, literary, educational, and similar purposes, including contributions to governmental agencies through which the gift is made for public purposes. Travel in behalf of volunteer charitable work is deductible at five cents a mile.

Under certain provisions, gifts above the 30 per cent ceiling may be carried over for as much as a five-year period.

Donations to private foundations remain under the 20 per cent ceiling, with certain exceptions. Still not eligible for deductions are gifts to candidates for public office, political parties, organizations seeking to benefit a particular group, organizations where there is a profit motive, subversive groups, organizations which attempt to influence legislation or engage in propaganda, etc. Gifts to fraternal or professional organizations are eligible for deductions only when the contribution goes to a special group set up within the organization for charitable, educational, or other approved purposes.

Interest — The taxpayer may deduct interest on a personal note to a bank or individual, a mortgage on his home, a life insurance loan if the interest is paid in cash, or interest on delinquent taxes.

Taxes — Deduction may be made for taxes paid on personal property or real estate, for city income taxes, retail sales taxes, and state gasoline taxes.

The following state and local taxes may not be deducted: Auto plate and driver license fees, cigarette and tobacco taxes, alcoholic beverage taxes, admission, occupancy and transfer taxes.

Casualty Losses and Thefts — The taxpayer may deduct losses due to destruction of property by fire, stolen property or cash, and storm damage, provided the amount is in excess of \$100 for each loss and provided the amount is not claimed as a business deduction and not covered by insurance.

Retirement Income

Pensions and annuity payments received by individuals fall into three classes for federal income tax purposes: Nontaxable, fully taxable, or partly taxable. Certain items of retirement income also may be sub-

ject to credit, allowances varying according to whether the retired person is under age 65, over that age, or over age 72. A person who is receiving retirement income, therefore, would do well to check with an office of the Internal Revenue Service, or consult a tax expert.

Standard Deduction

In lieu of listing amounts paid for nonbusiness deductible items, under the Revenue Act of 1964, the taxpayer may elect to use the 10 per cent standard deduction, or the minimum standard deduction. However, both husband and wife must use the same method. The minimum standard deduction is computed as follows: \$200 (\$100 if married and filing separate returns) plus \$100 for each exemption claimed on Schedule A, of the return, including exemptions for age and blindness. The deduction is limited to \$1,000 (\$500 if married and filing a separate return). Consideration should be given to this provision in determining the amount to be entered on line 2 of the Tax Computation Schedule on page 2 of Form 1040-ES.

Other Provisions

Dividends paid out of a corporation's current or accumulated earnings are taxable. The first \$100 of such dividends are tax-free when the taxpayer takes the dividend exclusion. On a joint return the exclusion may be up to \$200.

An individual who is 65 or older may exclude from gross income, any capital gain attributable to the first \$20,000 of the sales price of his personal residence. Provided the property has been owned and used by him as his principal residence for at least 5 years during the 8-year period preceding the sale.

The taxpayer who, because of employment, must engage a sitter for a child up to age 13, or for a physically or mentally defective dependent, may qualify for deductions on expenses for this purpose.

Partnerships

The partnership itself is not subject to income tax, but is required to file an information return, Form 1065. Tax liability falls upon the individual partners. Simple agreements for the sharing of expenses, co-ownership and maintenance of property, and the like, are not considered partnerships, unless a profit element also is involved.

Where an actual partnership exists, partners would do well to seek expert advice in regard to tax liability. An Opinion of the Ohio Attorney General given in 1961 permits professional men to associate as partnerships under Ohio limited partnership law and thus make themselves eligible for favorable tax action under the U.S. Internal Revenue Act.

Professional Corporations

In 1961, the Ohio Legislature enacted Sections 1785.01 through 1785.08 of the Ohio Revised Code,

authorizing members of certain professions, including physicians, to form professional associations. A number of other states have enacted similar legislation. One of the primary purposes of the legislation was to make it possible for associations of professional persons to be treated as corporations for federal tax purposes.

A number of such professional associations have been incorporated under Ohio law, and have made application to IRS for special tax benefits. At latest report, none of these associations had been approved for special tax treatment. The Ohio State Medical Association has gone on record requesting the Internal Revenue Service to take no unfavorable action that would change regulations in regard to tax treatment of professional associations.

Similar laws have been enacted in some 34 other states.

Retirement Programs for Self-Employed

Beginning in 1968, the 50 per cent limitation on deductible contributions to retirement programs for self-employed persons is lifted. For 1967 the former rule still applies.

The Self-Employed Individuals Tax Retirement Act, better known as the Keogh Act, was enacted in 1962. H. R. 13103, signed by the President late in 1966, doubled the tax deduction benefits available under the act, effective in 1968, and offers certain other advantages. (Refer to the April, 1967 issue of *The Journal*, page 525, for a discussion of provisions of the act.)

Physicians who are contemplating establishing retirement programs, or revamping present plans, would do well to investigate the advantages and perhaps disadvantages of programs under this act. Any such program must apply to employees under specified conditions as well as to the self-employed individual.

District Office and Districts

Income tax payments and returns must be made at or mailed to the office of the District Director of Internal Revenue for the district in which the taxpayer has his legal residence. There are two districts in Ohio. Counties comprising each district follow:

For the Cincinnati District — Director of Internal Revenue, 550 Main Street, Cincinnati, Ohio 45202, comprising the following counties: Adams, Athens, Brown, Butler, Clark, Clermont, Coshocton, Clinton, Delaware, Fairfield, Fayette, Franklin, Gallia, Greene, Guernsey, Hamilton, Highland, Hocking, Jackson, Knox, Lawrence, Licking, Madison, Marion, Meigs, Miami, Montgomery, Morgan, Morrow, Muskingum, Noble, Perry, Pickaway, Pike, Preble, Ross, Scioto, Union, Vinton, Warren, and Washington.

For the Cleveland District — Director of Internal Revenue, 220 St. Clair Ave., N. W., Cleveland,

Ohio 44113; comprising the following counties: Allen, Ashland, Ashtabula, Auglaize, Belmont, Carroll, Champaign, Columbiana, Crawford, Cuyahoga, Darke, Defiance, Erie, Fulton, Geauga, Hancock, Hardin, Harrison, Henry, Holmes, Huron, Jefferson, Lake, Logan, Lorain, Lucas, Mahoning, Medina, Mercer, Monroe, Ottawa, Paulding, Portage, Putnam, Richland, Sandusky, Seneca, Shelby, Stark, Summit, Trumbull, Tuscarawas, Van Wert, Wayne, Williams, Wood, and Wyandot.

INCOME TAX WITHHOLDINGS

Every employer who pays wages to one or more employees, where an employer-employee relationship exists, must withhold from such wages and pay over to the Federal Government periodically an amount prescribed by law.

Income taxes are not withheld for domestic servants, agricultural workers, and certain other persons to whom wages are paid.

Withholdings do not apply to the self-employed person's income since he pays through the estimated tax procedure.

The amount to be deducted from each pay check may be determined by referring to the *Employer's Tax Guide Circular E* after having the employee fill out Form W-4 to determine the number of exemptions he claims. The handbook is supplied by the District Office of the Director of Internal Revenue.

The employee who has reason to believe that his withholdings will not cover his tax liability may elect to claim fewer exemptions than he is entitled to, or request the employer to withhold an additional amount.

The amount deducted is paid to the District Office of the Director of Internal Revenue together with report on Form 941, for the calendar quarter, during the month immediately following the quarter for which deductions are made. Social Security taxes withheld from employees' wages and the employer's matching contributions are reported on this same form. Self-employment social security taxes are not reported on this form.

The employer is required to give each employee from whose wages he has withheld income tax during the year a statement in duplicate showing the amount of tax withheld and wages paid for that year. Forms W-2 in quadruplicate are supplied for this purpose. The original copy of Form W-2 is to be filed with the Employer's Quarterly Federal Tax Return, Form 941, for the last quarter. The second and third copies are furnished the employee and the fourth copy retained by the employer for his records. Statements must be furnished employees and reports made to the government between January 1 and January 31, for the previous year.

Deposit of Withholdings

An employer who withholds as much as \$100 per month for the purposes of income tax liability and F.I.C.A. liability (employer's and employee's shares) shall take these funds with Form 450 to a bank and deposit them. The bank transmits this form to the Federal Reserve Bank in Cleveland for validation, after which it is returned directly to the employer. The depository receipt, Form 450, is then eligible for use.

Report of Funds Paid

Payments made during the year for interest of \$10 or more, rents, or commissions, not subject to withholdings of \$600 or more and paid to anyone other than a corporation, must be reported on Form 1099 and transmitted with Form 1096, on or before February 28 of the following year to the Director, Internal Revenue Service Center, 222 East Central Parkway, Cincinnati, Ohio 45202. Sec. 6652 provides penalties for failure to file these statements.

SOCIAL SECURITY TAXES

The Social Security Amendments of 1965 brought doctors of medicine under provisions of the Old-Age, Survivors, and Disability program, whether employees or self-employed persons.

For physicians on salary the social security tax is withheld as a payroll deduction. (See under heading Social Security for Employees.) Interns and residents come under the same provisions as other employees for social security tax purposes.

EDITOR'S NOTE: As this issue went to press, H.R. 12080, which incorporates changes in the Social Security tax structure for 1968, was pending in Congress, but with virtual assurance that some version would be passed. Watch for additional information on this subject.

For 1967 the self-employed taxpayer pays a rate of 6.4 per cent on the first \$6600 of net earnings. This amount includes 0.5 per cent for hospital insurance. The same percentage deduction and wage base extend through 1968.

The social security tax on self-employment earnings is to be paid quarterly with the Declaration of Estimated Tax (Form 1040ES).

The physician who has a part-time salaried position through which social security taxes are withheld need not pay the self-employment tax if social security taxes are withheld on income up to \$6600. If the salary subject to withholdings is less than \$6600, he must pay self-employment tax on the difference between the maximum and his salary.

Since physicians unless on salary were not included under the social security program prior to enactment of the Social Security Amendments of

1965, most of them will have to accumulate credit before becoming eligible for full benefits.

The physician who paid his first social security tax for 1965 began to accumulate credit under the Old-Age, Survivors, and Disability program as of January 1, 1965. Interns and residents who came under coverage for the first time on January 1, 1966, began to accumulate credit at that date, except for previous non-professional employment.

Federal Health Insurance Programs

The Medicare program is in two parts: (1) hospital insurance, and (2) medical insurance.

Physicians become eligible for benefits under both parts of the program on the same basis as other individuals. Physicians who have recently come under social security coverage for the first time may disregard accumulation of credits for health insurance purposes. Beginning in 1968 accumulation of credit becomes a factor in eligibility.

Persons who are approaching age 65 and wish to take advantage of the hospital insurance program should notify the Social Security office at least a month before reaching age 65. Retirement is not a factor in eligibility for either the hospital insurance or the medical insurance programs.

Persons aged 65 and over are eligible for benefits under the medical program provided that they enroll during a specified enrollment period and agree to pay \$3 a month into the medical program fund. In general, persons approaching age 65 have an enrollment period of seven months beginning three months before they attain age 65. General enrollment periods are from October 1 to December 31, in each odd year, beginning in 1967. No person may enroll more than three years after the close of the first enrollment period in which he could have enrolled.

Benefits under the medical program are for the individual enrollee only. The spouse who is aged 65 must enroll also if benefits are desired for both husband and wife.

Social Security for Employees

As employers, physicians will be interested in the following provisions of the law:

Every employer of one or more employees is required by law to deduct social security taxes from the employee's wages and to contribute a matching amount himself.

For 1967 the rate is 4.4 per cent each for the employee and the employer, with deductions made on the first \$6600 of wages. This amount includes 0.5 per cent for the health insurance program. The same percentage deduction and wage base extend through 1968.

The tax return and the informational return combined in one report is to be filed quarterly during the month after the quarter ends.

Employees Receiving Benefits

For the benefit of physicians who employ persons now receiving social security benefits, the following information is presented:

A worker under age 72 who is receiving benefits under the social security program will not lose any payments unless he makes more than \$1500 in a year. If he makes more than that amount certain deductions apply to his benefits. A person over age 72 may earn any amount and not lose benefits.

Both men and women may elect to receive benefits after age 62 at somewhat reduced rates. The widow of an insured worker may elect to receive benefits after age 60 at reduced rates.

A disabled worker whose disability is expected to last for at least 12 months may qualify for disability benefits beginning with the seventh month of disability. The Social Security Amendments Act of 1965 liberalized the requirements affecting people who are disabled by blindness.

Benefits to a child who is eligible to receive such benefits continues through age 21, if the child is a full-time student in an accredited school. If the child is not a full-time student, benefits continue to the 18th birthday.

Not covered for social security purposes is work done by a child under 21 for his parent, by a husband for his wife, or by a wife for her husband. This applies also to foster or step-relationships. Services performed by or for "in-laws" and relatives other than those named are covered, provided a genuine employment relationship exists.

Under current provisions, work that a parent does for a son or daughter in the course of a trade or business is covered by Social Security. However, work done in the household of a son or daughter is not covered.

Domestic workers in private homes who receive wages of at least \$50 in a quarter are covered. In other words, if a taxpayer has a cleaning woman, or other domestic worker, only one day a week, she must be covered if she earns \$50 or more in a quarter (approximately \$3.85 per week). Domestic workers in farm homes come under the same provisions as farm workers.

A farm worker who earns \$150 in cash wages during the year must be covered. However, farm workers who perform agricultural services for an employer on 20 or more days during a calendar year for cash at a rate based on some unit of time must be covered regardless of the rate.

Only cash is considered in wages paid to domestic or farm workers, not wages in kind.

UNEMPLOYMENT TAX

Physicians or other employers who have three or more employees, including other physicians, nurses, receptionists, technicians, office workers, etc., are subject to the Ohio Unemployment Compensation Tax.

Those who have four or more are liable also for the Federal Unemployment Insurance Tax.

In professional associations incorporated under Ohio S.B. 550, members of the group are counted as employees.

Ohio Unemployment Compensation Tax

In general, employment of three or more persons renders the employer liable for this tax. Excluded from the number of employees is a minor who does short-time work but whose principal occupation is that of student, and a person doing casual labor not in the course of the employer's regular business or profession. Careful consideration should be given to an extra worker as to whether he should be included as an employee or as an independent contractor. A cleaning woman, for example, who works only a few hours a week, but who comes in regularly, would probably be classed as an employee. A physician who is in doubt as to his liability should request clarification from the Ohio Bureau of Employment Services, 145 South Front St., Columbus, Ohio 43216; phone 469-2579.

Reports are made during the month following each calendar quarter on forms supplied by the Bureau. The tax is established for each employer annually. A copy of the calculations made by the Bureau is mailed before the first of the year to each employer. This form also shows how the rate was calculated.

Rates for 1968 will be further reduced from those currently in effect, reflecting the improved employment picture in Ohio. The emergency rate assessment is no longer necessary and any 1968 rates will range from zero to a maximum of 4.1 per cent.

While employers with a zero rate will have no tax to pay in 1968, they are required to furnish the quarterly contributions report the same as all other employers.

Only the first \$3,000 paid by any employer to any one individual "in employment" within a calendar year is taxable.

Penalties are specified in the Ohio Code for failure to comply with provisions of the law.

Liable employers should furnish a form BUC-400 to each employee upon separation. These forms may be obtained from the local employment office. If the employee files a claim for benefits, the bureau will request separation and wage information from the employer. These forms should be returned within seven days of receipt.

Federal Unemployment Tax

The Federal Unemployment Insurance Tax applies to employers who have four or more persons on their payrolls on 20 or more days in the calendar year, each of the 20 days being in different calendar weeks. It is payable to the District Director of Internal Revenue by January 31 for the previous year.

The tax is on the first \$3,000 paid to an employee. A considerable credit is allowed on all payrolls which are reported to the state unemployment compensation agency, and on which the tax is paid (see under Ohio Unemployment Compensation Tax). If an employer has paid his state unemployment tax in full, the federal tax is reduced to a minimum.

OHIO WORKMEN'S COMPENSATION

The purpose of the Bureau of Workmen's Compensation is to maintain a Workmen's Compensation Insurance Fund from which to pay compensation to workmen for injury or occupational disease and compensation to dependents for death occasioned in the course of or arising out of employment.

Every employer in the state employing three or more employees regularly in the same business is required to furnish the Bureau of Workmen's Compensation with specified information about employees he has had during the previous year, and to contribute to the State Insurance and Occupational Disease Fund in an amount based on the payroll and at a premium rate based on the class of risk. (The employer under certain circumstances may elect under bond to comply with the provisions of the law by self-insuring the risk.)

Employers of less than three employees may voluntarily subscribe to and obtain insurance in the Fund.

Insurance accounts are adjusted and reports made for the first half and second half of the calendar year. Reports are due with premiums attached by August 1 for the first half of the year, and by February 1 for the second half of the year. Another requirement is an advance permanent deposit based on eight months estimated payroll for the periods January 1 - August 31 and July 1 - February 28, respectively.

The Bureau of Workmen's Compensation comprises 16 regional offices in addition to the central office in Columbus.

Disabled Workmen's Relief Fund

Effective in 1959, the Ohio General Assembly increased permanent and total disability benefits and enacted Senate Bill No. 472 to finance this increase by levy of an excise tax on employers of 3 cents per \$100 of total aggregate gross payroll. This excise tax applies to employers of three or more employees, and to employers of less than three persons who have voluntarily subscribed to the Workmen's Compensation Insurance Fund; also self-insured employers. Report for the calendar year with premium is due by March 1 of the following year.

OHIO PERSONAL PROPERTY TAX

Returns under the Ohio Personal Property Tax Law must be made between February 15 and April 30 annually. One-half of the amount of the tax is paid

when the return is filed, and the other half is due September 20.

Personal Property Tax Forms 910 and 911 may be obtained from the county auditor's office.

Where a taxpayer holds property used in business in more than one Ohio county, he must file on Form 945. This form is obtained from the Department of Taxation, 68 East Gay Street, Columbus. Taxes on intangible property of corporations having property in more than one county is paid to the State Treasurer on forms furnished by the Department of Taxation. For corporations the entire amount of intangible property tax must be paid on or before July 20 and the tangible personal property tax on or before September 20.

Certain changes have been written into the law in regard to some assessment valuation and rates, but these changes will be reflected in the new tax forms distributed for the current tax period. Rather extensive changes have been made in regard to farms and farm property.

It must be kept in mind that tangibles to be listed include personal property used in business, such as a physician's office furniture, fixtures, equipment, supplies (including medicines), etc. Such tangible property should be listed at its true value. Counting the year of purchase as a half year, a depreciation of 10 per cent annually from cost will be allowed until such equipment reaches a value of 30 per cent. It should stop at that figure for a year. Then such office equipment may be reduced $2\frac{1}{2}$ per cent each year until it reaches a minimum value of 20 per cent, which value should be kept as a utility value.

It should also be noted that personal investments such as corporation stocks, notes or mortgages, etc., are also taxable and must be returned in the personal property tax report along with business property.

When a physician opens his practice (or a person starts in business) during the calendar year, he is required by law within 90 days of time of opening to list all of his taxable property, as of the date he engaged in practice. The valuation of all taxable property to be returned for taxation is determined by multiplying the value by the number of remaining months in the year and dividing the result by 12.

Forms 937 and 902, obtained from the County Auditor, must be filed with the Personal Property Tax return to obtain a lesser value than 20 per cent.

Returns should be filed in duplicate. The so-called tangible tax statutes are intricate and complicated so each physician having taxable personal property for listing should obtain competent advice in case of doubt as to the meaning of any of the provisions of the law.

Accounts receivable are to be listed in accordance with Section 5711.18 of the Revised Code part of which reads, "Claim for any deduction from net book

value of accounts receivable or depreciated book value of personal property must be made in writing by the taxpayer at the time of making return," on supplemental tax form 902.

To arrive at a fair estimate of his current accounts receivable, the physician is advised to note after each account what he considers its value. If he believes the account can be collected in full, it should be listed at its full face value. Otherwise it should be listed at a percentage of its true value, or "no value" if that is the case. The total of these estimates is the amount to be entered as "current accounts receivable" and used in computing credits.

This procedure permits the physician to charge off bad debts. It also allows him to depreciate the actual value of accounts returned in the tax year, but which have decreased in actual value during that year.

All taxable personal property and credits used in business shall be listed as of the close of business of the last day of December, annually, or the last day of the fiscal year.

As defined in Section 5701.07 R. C., credits mean "the excess of the sum of all current accounts receivable and prepaid items used in business when added together estimating every such account and item at its true value in money, over and above the sum of current accounts payable of the business, other than taxes and assessments."

The same section states that "current accounts include items receivable or payable on demand or within one year from the date of inception, however evidenced."

It should be understood that there is no discrimination in the foregoing provisions against physicians. Every person who possesses intangible assets, such as accounts receivable, or any business or professional man who does business on a credit basis, must return his accounts receivable for taxation.

OHIO SALES AND USE TAX

Section 5739.02 Revised Code levies an excise on each retail sale made in Ohio of tangible personal property.

In Section 5739.01, under the definition "vendor," the Revised Code states: "Physicians, dentists, hospitals, and veterinarians who are engaged in selling tangible personal property as received from others, such as eye glasses, mouth washes, dentifrices, or similar articles, are vendors."

Under the definition of "consumer," the Code states: "Physicians, dentists, hospitals, and blood banks operated by nonprofit institutions and persons licensed to practice veterinary medicine, surgery, and dentistry are consumers of all tangible personal property purchased by them in connection with the practice of medicine, dentistry, the rendition of hospital

or blood bank service or the practice of veterinary medicine, surgery, and dentistry."

The Ohio Use Tax Law, passed in 1936, supplements the Retail Sales Tax Law and imposes a tax on the same basis as the sales tax on purchases made outside the State. Its purpose is to protect Ohio merchants from discrimination. Many out-of-state firms have made arrangements with the Office of the Tax Commissioner to add the amount of the tax to invoices covering purchases by Ohio consumers, collecting the tax, and paying it directly to the Department.

However, if a physician purchases drugs or supplies from an out-of-state firm which has not made such an arrangement with the Office of the Tax Commissioner, he is required to report such purchases to the Treasurer of State and pay the tax. Returns must be filed with the Treasurer by April 15 for purchases, during the period January 1 to March 31, and quarterly thereafter. The report is filed on Ohio Use Tax Form 1014, "The Quarterly Consumers Return."

The Ohio General Assembly increased the rate from 3 to 4 per cent, effective as of September 1, 1967, but otherwise the law remains the same.

Forms are routinely sent to physicians on record, who have been assigned a Used Tax account number. Physicians who have not been assigned an account number should write to the Office of the Tax Commissioner.

CITY PAYROLL TAXES

Many municipalities in Ohio have enacted laws imposing income taxes on wage earners and placing the primary responsibility on the employer to make payroll deductions, file forms, and pay taxes to the city government. This responsibility falls upon a self-employed person, such as a physician in private practice.

Laws vary as to liability of a person who earns the major part of his income in one community and resides in another. The physician who moves into a new location would do well to inquire as to local tax laws.

WHAT TO WRITE FOR

Suicide in the United States, 1950-1964 — Narrative description and statistical tables; a USPHS pamphlet with data from the national vital statistics system. PHS Publication No. 1000 — Series 20 — No. 5; for sale by the Superintendent of Documents, U. S. Government Printing Office, Washington, D. C. 20402; price 30 cents.

Carbon Monoxide: Number One on List of Air Pollutants

Carbon monoxide is a common pollutant of the air, especially that of the cities, due in great part to the concentration of motor vehicles in the urban areas.

Deaths caused by carbon monoxide receive much attention; illness associated with carbon monoxide poisoning receives much less attention. The burning of gasoline in the automobile and discharge of the residue from the exhaust results in carbon monoxide pollution of the air. Concentrations of 100 parts of carbon monoxide to 1,000,000 parts of air may cause dizziness, headache, delayed reaction time and other symptoms of carbon monoxide poisoning. Higher concentrations may cause death.

When coal, petroleum, and gas is burned, the gas, sulfur dioxide, is produced; also, sulfur trioxide, which, in the atmosphere, converts to sulfuric acid. When the air containing these substances is breathed, irritation of the respiratory passages ensues. Studies have demonstrated that the respiratory diseases increased as the sulfur oxides levels increased.

In incomplete burning of almost any material or substance there is discharge of hydrocarbons into the air. Most of these hydrocarbons are not considered harmful in the amount ordinarily found in polluted air. However, certain hydrocarbons may be cancer-producing agents in the polluted air.

Photochemical smog is a mixture of gases and particles manufactured by sunlight out of the nitrogen oxides and hydrocarbons. Smog has been observed in every region of the United States. It is more common in urban areas than rural. It causes irritation of the eyes, nose, throat, and is believed to reduce resistance to respiratory infection and disease.

Air pollution is the cause of much economic loss and destruction of plant life. The cost to each individual has been estimated annually to be \$65; the property damage anywhere from \$11 to \$13 billion dollars annually. — By I. C. Riggin, M. D., Amherst — One of a series of briefs presented in behalf of the OSMA Committee on Environmental and Public Health.

The Cleveland Nationalities Services Center selected Dr. Bruno Gebhard, founder of the Cleveland Health Museum, and member of the Department of Preventive Medicine at Case Western Reserve University, to receive the Golden Door Award. The award is presented to Americans of foreign birth who have made outstanding contributions to American life and culture.

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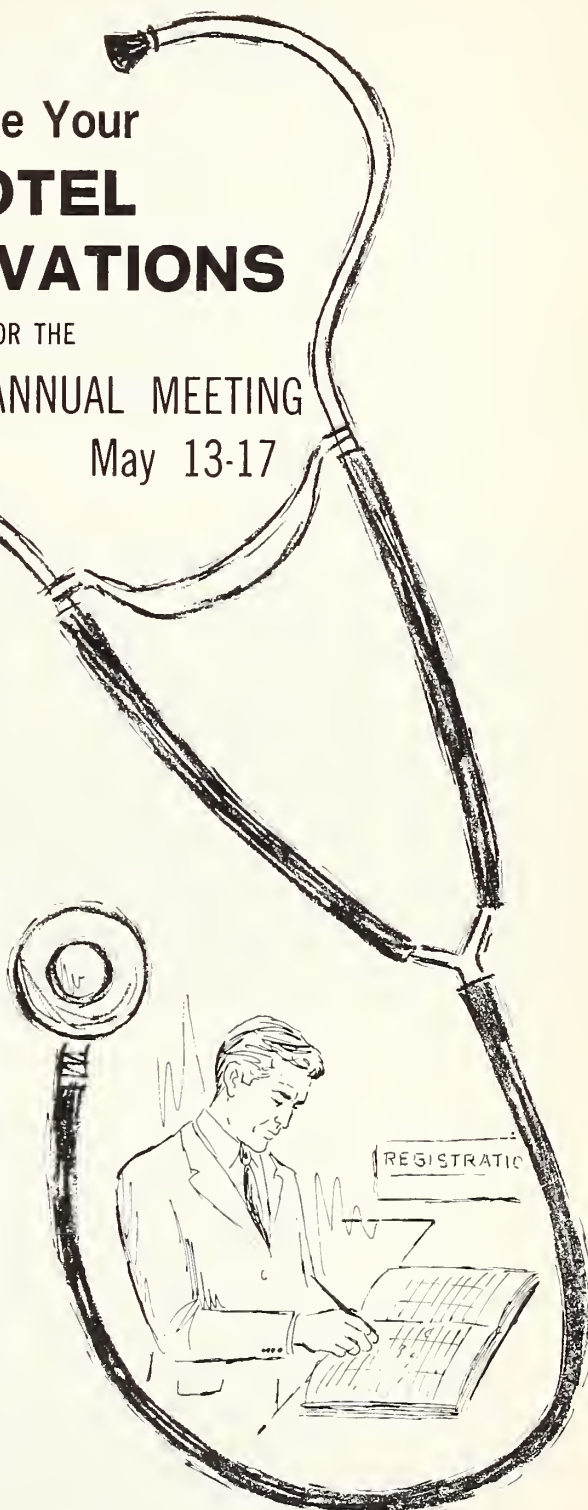
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Outstanding Scientific Exhibits At OSMA Annual Meeting

FEATURES at the 1967 OSMA Annual Meeting in Columbus, May 15-19 included the Scientific Exhibit and its companion Health Education Exhibit. From the many Scientific Exhibits on display the judging committee selected certain ones as outstanding. This procedure was in keeping with a recommendation of the Committee on Scientific Work approved by The Council. The authorized award in each case consists of a certificate of recognition, a permanent type plaque, and, in the case of the gold, silver, and bronze awards in the two fields of teaching and original investigation, monetary gift. A summary of exhibits selected to receive awards was printed in the July issue of *The Journal*, and illustrated articles in subsequent issues featured individual exhibits selected. The following brief descriptions bring to a conclusion this series of articles on outstanding exhibits of the 1967 OSMA Annual Meeting.

Exhibit on Jaundice in Infants Given Honorable Mention

Honorable Mention in the Teaching Field was given the exhibit entitled "Jaundice in the Infant," at the 1967 OSMA Annual Meeting in Columbus. Sponsors were William M. Michener, M.D., and Robert Ewald Hermann, M.D., both of the Cleveland Clinic Foundation, in Cleveland.

Sponsors of the exhibit call attention to the fact that the infant with prolonged jaundice presents a diagnostic problem. No single test is definitive and multiple testing confuses the issues. Frequently observation without complete evaluation in unexplained jaundice is the only recommended procedure.

The exhibit presented the differential diagnosis with reference to the mechanism of jaundice, recommended diagnostic tests including experiences with I^{131} rose bengal liver scans, and liver biopsies and cholangiograms obtained at surgery in infants with different diseases causing jaundice.

The exhibit consisted of four panels: Differential Diagnosis, diagnostic studies, operative liver biopsy, and cholangiograms and prognosis. The exhibit was oriented toward presenting to the physician step-wise procedures in evaluating the infant with jaundice.

* * *

Circulating Tumor Cell Exhibit Awarded in Research Field

The Bronze Award in the field of Original Investigation was presented to the exhibit, entitled "Demonstration of Circulating Tumor Cells," sponsored by Emmerich von Haam, M.D., and Thomas D. Stevenson, M.D., of Ohio State University College of Medicine, Columbus.

The exhibit presented illustrations and text which

described the status of examination of peripheral blood for circulating tumor cells.

Representative examples of tumor cells recovered from the blood of patients were displayed along with histologic characteristics of primary tumors and other types of cytologic examinations. The techniques utilized in examining blood for circulating tumor cells was described as well as some of the potential sources of error.

The use of fluorescent methods were briefly described as well as changes occurring in normal cells in individuals with cancer—the so-called "malignancy associated changes." The principal purpose of the exhibit was to summarize progress in that particular field of cytologic research for the practitioner.

* * *

Coronary Angiography Exhibit Awarded in Teaching Field

The Bronze Award in the Teaching Field at the 1967 OSMA Annual Meeting was awarded to the exhibit, entitled "Selective Coronary Angiography." Sponsors were William Molnar, M.D., Karl P. Klassen, M.D., and Edward Cousins, R.T., University Hospitals, Ohio State University, Columbus.

This exhibit portrayed techniques that have been under study at University Hospitals for years in the field of coronary angiography. Dr. Molnar is in the Radiology Department, and Dr. Klassen on the thoracic surgery service. Mr. Cousins is associated with the Radiology Department.

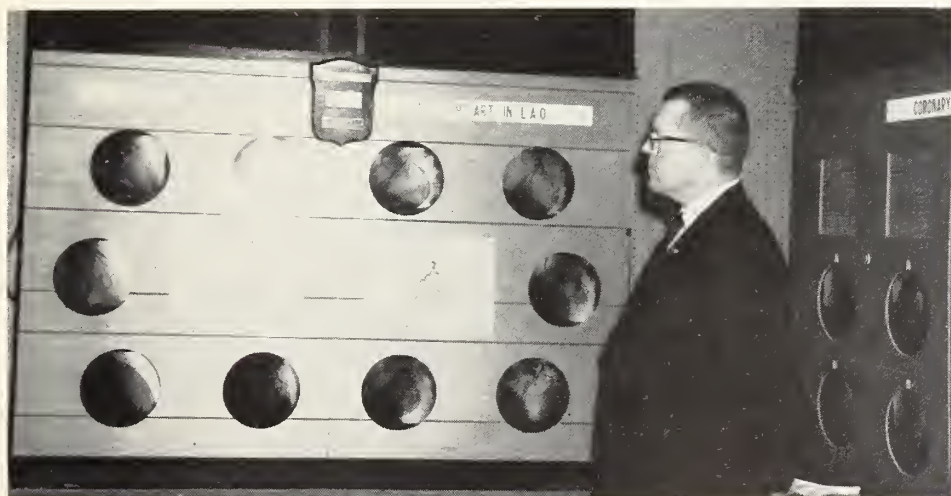
Illustrations of visualized coronary arteries were presented contrasting normal anatomy and pathologic changes. The illustrations were enlarged copies taken from 35 mm. movie frames used for demonstration purposes and in the teaching program.



Dr. Lawrence C. Meredith, 1966-1967 OSMA President, left, congratulates Dr. William M. Michener, co-sponsor of the exhibit "Jaundice in the Infant," Honorable Mention winner in the teaching field at the 1967 OSMA Annual Meeting.



Bronze Award winner in the field of original investigation was the exhibit "Demonstration of Circulating Tumor Cells," Dr. Meredith is presenting the mounted plaque to Miss Margaret J. Cameron, who helped man the exhibit for the Pathology Department at OSU.



This exhibit, "Selective Coronary Angiography," sponsored by a team from University Hospitals, Columbus, won the Bronze Award in the teaching field. Dr. Meredith is viewing the exhibit to which the mounted plaque has been attached.



CALL FOR ENTRIES

SCIENTIFIC AND HEALTH EDUCATION EXHIBITS

1968 Annual Meeting, Ohio State Medical Association

May 13 - 17, Cincinnati, Ohio

OUTSTANDING among the features of the 1968 Annual Meeting of the Ohio State Medical Association, May 13-17, Cincinnati, Ohio (exhibit days May 14-17) will be the Scientific and Health Education Exhibits. This will be the first time OSMA will use the excellent facilities of the Cincinnati-Exposition Center. Let's make 1968 a record-breaking year on exhibits.

Presentations will be limited to (1) exhibits by Ohio physicians, Ohio medical schools, hospitals or similar organizations; (2) out-of-state physicians or out-of-state agencies on invitation; (3) voluntary health organizations.

Each exhibitor will be provided with a booth or wall space, a standard sign, necessary electrical outlets, shelves, transparency cases, and a reasonable amount of furniture. If additional special facilities, equipment, or furniture are needed for the proper showing of the exhibit, the exhibitor should consult the chairman of the committee, Samuel Saslaw, M. D., and obtain his approval. The Association will not pay for special facilities, equipment, and furniture unless the request is approved in advance by the chairman.

On the opposite page will be found an application blank. If you have material suitable for an exhibit, send in an application. If you know of a colleague or group of physicians who have interesting material to display, suggest that they do the same. Deadline for entries in the Scientific and Health Education Exhibits are January 30, 1968.

A watchman will be on duty during the meeting but it is agreed that exhibitors will indemnify and hold harmless the Ohio State Medical Association from all liability which may ensue from any cause whatsoever.

Cost of transporting exhibits to the meeting must be borne by the individual exhibitors as well as the costs of cards, signs, etc., which are a part of the exhibit.

The picture on the facing page shows the type of booth which will be provided.

The booths will be of uniform color and design. Back and side walls will be pegboard, making them extremely functional for accommodating all kinds of charts and specimens. Blue fluorescent fixtures are a part of the background and will be spaced on each exhibit to give adequate lighting. If special lighting is needed, this should be noted in application for space.

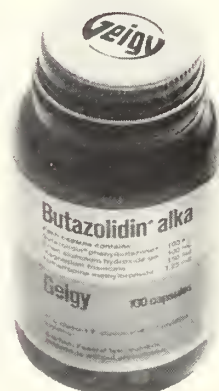
In rheumatoid arthritis, Butazolidin alka needs only a week's trial. If it doesn't work in a week, forget it.

A short trial period may spare patients weeks of discomfort. That's one reason why Butazolidin alka seems a good choice when aspirin fails.

It's not for every patient. Check carefully the Contraindications, Warning, and Precautions shown below.

And adverse reactions may occur. The most common are nausea, edema and rash. Rarely, agranulocytosis has been reported. All adverse reactions are listed below, too.

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foliative dermatitis, Stevens-Johnson syndrome, or a generalized allergic reaction similar to serum sickness may occur and require permanent withdrawal of medication. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

Dosage in Rheumatoid Arthritis: Initial: 3 to 6 capsules or tablets daily in 3 or 4 equal doses. Trial period: 1 week. Maintenance dosage should not exceed 4 capsules or tablets daily; response is often achieved with 1 or 2 capsules or tablets daily. 6509-V(B)R2

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ACCREDITATION NOTES . . .

A Question-and-Answer Column Conducted in Collaboration with
The Joint Commission on Accreditation of Hospitals
John D. Porterfield III, M. D., Director



Q. Does the Joint Commission require specific method of recording professional examinations (laboratory, radiologic, EKG, etc.)? May the medical staff of the hospital, through its duly constituted Record Committee, determine the nature of such recording?

A. No. Yes. How such reports are made to the medical staff and incorporated in the patient's record is at the discretion of the medical staff, so that there is the most effective communication of clinical intelligence. JCAH does require verification and assignment of responsibility by appropriate signatures and objects to the use of abbreviations not universally recognizable. It also urges that the originals go into the patient record. Otherwise, it's your practice and your diagnostic resources.

Q. Why is so detailed a discharge summary needed? This is more time consuming than the history and physical examination. Is this principally to save time, at the expense of the physician's time, to supply information to insurance companies, federal government agencies, and other third parties?

A. A detailed discharge summary is not needed. Summation of the hospital episode should contain only the pertinent highlights of the patient's course in the hospital and constitutes the professional record of the discharge interview with the patient. Usually, it should take less than three minutes to dictate. A copy of it should go to the attending physician's office after the patient is discharged for his use in the subsequent care of the patient. Other conveniences it may provide are only supplementary. Doctor Arndal, Chief of the Hospital Accreditation Program, has an excellent reprint on the subject, available from the JCAH for the asking.

Q. Recommended committees of JCAH are (1) Executive, (2) Record, (3) Joint Conference Committee, (4) Credential, and (5) Tissue. In a hos-

pital with 40 beds and staff of only five men, may these committees be combined as "The staff as a whole"?

A. Yes. Presently, JCAH standards do not require committees as such, but the medical staff shall routinely perform certain functions, which may be carried out by committees, committee of the whole, or any other demonstrably effective way. Required functions are: executive, credentials, coordination and communication with governing body, medical audit including record completeness and pertinence and effective hospital resource utilization; control of adventitious infections, pharmacy policy and accreditation. See Bulletin #40, JCAH, January, 1966.

Columbus Pathologist Receives National Cytology Award

Emmerich von Haam, M.D., recently retired as chairman of the Department of Pathology at Ohio State University's College of Medicine, received the Papanicolaou Award at a recent meeting in Denver, Colorado.

Given by the American Society of Cytology, the award includes a bronze medal and an honorarium. It is given to men and women who have made "meritorious contributions" to cytology, the scientific study of cells. It has been given only six times previously, and was awarded to Dr. von Haam during the 15th annual meeting of the Society.

Dr. von Haam, who served as president of the society in 1962 and is now its secretary-treasurer, told the assembled group about new findings which are a result of his extensive research of cancer in the cervix. His investigations indicate that there are several kinds of cancer in situ of the cervix, while previously it was thought that only one type existed. Dr. von Haam recently received a \$250,000 grant from the National Institutes of Health to continue his studies of cervical cancer.

Activities of County Societies ...

ASHLAND

The Ashland County Medical Society sponsored a measles immunization program during the month of October. The public was urged to have all children up to age 12 immunized by going to a physician's office. A nominal fee was announced. To prevent bunching up, persons seeking immunization were urged to come on certain days designated according to alphabetical order of last names.

CLERMONT

The regular dinner meeting of the Clermont County Medical Association was held on October 18 at the Homestead Inn, Milford. Dr. Nico Capurro, president, presided, and there were eight members present.

Correspondence from the Cincinnati Hospital Council in regard to pediatrics and obstetrical beds at the Clermont County Hospital was discussed.

The resignation of Dr. Albert W. Van Sickle from the office of secretary-treasurer was announced. Dr. Raymond L. Davidson was appointed to fill the unexpired term as secretary-treasurer.

A resolution was made part of the minutes recognizing the outstanding service of Dr. Van Sickle as a past president of the Society and its secretary-treasurer. Dr. Van Sickle was further commended for his outstanding work as health commissioner of Clermont County for almost six years. Dr. Van Sickle has accepted appointment as health commissioner of the City of Hamilton.

The immunization clinic in Batavia was discussed. Ninety-one immunizations were given children in the clinic during September. Dr. Davidson volunteered to accept responsibility for assignment of

physicians at the clinic, a task formerly performed by the late Dr. Phillips F. Greene.

CUYAHOGA

The Academy of Medicine of Cleveland and Cuyahoga County Medical Society recently published its annual Directory of Officers and Committees for the 1967-1968 season. The roster includes some 22 specialty societies, Woman's Auxiliary officers, and other data.

FRANKLIN

The Academy of Medicine of Columbus and Franklin County recently published its Annual Membership Roster and Information Directory.

In the information section are Standards of Practice Governing Lawyers and Doctors of Medicine, A Code of Cooperation between physicians and the press, and other data.

GEAUGA

The Geauga County Medical Society held its September meeting at the Berkshire Hills Country Club in Chesterland.

State Senator Robert Stockdale was invited as the guest speaker and graciously took time out from his busy schedule to appear at the dinner.

The Medical Society has as one of its purposes, the furthering of the physician's education in his non-medical civic roll of being a responsible and informed member of his community.

The Senator's speech traced a bill from its inception, to the floor of the Ohio Senate. He also spoke about politics and people, and the duty of people to politics. Perhaps the most important point he defined was that it is everybody's civic duty to be

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interested in politics, to inform himself on candidates and issues, and to take the time to vote and let his feelings become known. If we fail to exercise our political right to vote and show no interest; our government will soon be run by only a few and we may suddenly awaken one day to find that because we abdicated our political duty we are no longer a democracy.

The Senator's talk was enthusiastically received by the members of the Geauga County Medical Society and their guests. He received a standing ovation. Senator Stockdale left us, all of us, much food for thought. — Richard Sabransky, M. D., Secretary.

HAMILTON

The Academy of Medicine of Cincinnati met on October 17 at the Academy facilities, 322 Broadway.

"Continuing Medical Education, a Community Adventure," was the topic presented by Dr. James F. Schieve, director of continuing education, University of Cincinnati College of Medicine.

"The Expenditure of the Public Dollar" was the subject of discussion by Dr. James D. Wharton, Cincinnati health commissioner.

LORAIN

Lorain County Medical Society has presented the sum of \$1,596.91 to Lorain County Medical Foundation to be used in the Scholarship Fund.

The announcement was made by Robert S. Vandervort, M. D., president of the society, and a check for that amount was forwarded to Carl M. Adams who serves as chairman of the Board of Supervisors of the Medical Foundation.

The money represents the balance of funds in hand from the "End Measles" project sponsored by the County Medical Society last May, after expenses occasioned by the program had been met. This amount was realized because much time and service was contributed by members of the medical profession, nurses, and volunteers from several service and health-related organizations, clubs and schools, etc.

The project, co-sponsored by the Ohio Department of Health, immunized 5,180 children from one through seven years of age at several clinic sites throughout Lorain County.

The Lorain County Medical Foundation was initially established by the society with funds from the SOS Polio campaign held several years ago. — *The Journal*, Lorain.

LUCAS

The Bulletin of the Academy of Medicine of Toledo and Lucas County announced the following program in its November issue.

Northwestern Ohio Institute for Continuing Medical Education, November 15; guest speaker: Dr. Robert J. Baker, chief Trauma Unit, Cook County



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*Blood; ketones; glucose; protein, and pH.

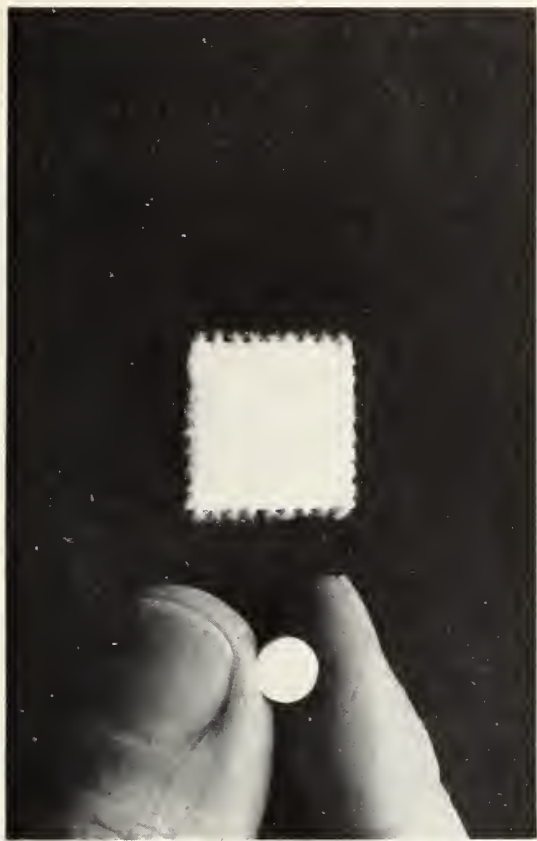
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Hospital, and Associate professor of surgery, University of Illinois;

Morning lecture at the Toledo Hospital, "Surgical and Orthopedic Trauma Care Discussion."

Afternoon lecture at the St. Charles Hospital: "Shock, Trauma, and Metabolism."

Buffet supper at the Academy of Medicine building.

Evening lecture: "Newer Methods of Treatment of the Acutely Injured Patient."

MAHONING

A combined meeting of the Corydon Palmer Dental Society and the Mahoning County Medical Society was held on October 17 in the Mural Room. Speaker for the occasion was Dr. Albert LeRoy Pursley, president of the Youngstown State University, who spoke on the topic, "The Future of Youngstown State University."

WAYNE

How physicians may take advantage of the new tax-sheltered Keogh pension plan for self-employed persons was explained by Robert L. Rupp, CLU, President of Robert L. Rupp and Associates, Columbus, at a well-attended dinner meeting of the Wayne County Medical Society, November 8, at Shisler's Restaurant, Orrville. The informative program included a film in color entitled "Give Yourself A Break."

The Ohio State Medical Association's 50-year award was presented to Dr. Nevin C. Mayer, Apple Creek, by Dr. William R. Schultz, Wooster, Councilor for the Eleventh District. A resume of Dr. Mayer's distinguished career as a general practitioner was given by Dr. Everett C. Burgess, Wooster.

Sixth District PG Day Program Draws Excellent Attendance

The Warren Tribune Chronicle devoted a full page to a pictorial report of the Sixth Councilor District Postgraduate Day Program held in Warren on October 25, and stated that an estimated 600 and more persons were in attendance. The program was held at the Packard Music Hall.

Program chairman was Dr. George Sudimack. The Trumbull County Medical Society was host organization, with Allan Schaffer, president, and Dr. Donn F. Covert, president-elect. Dr. Edwin R. Westbrook, Councilor of the Sixth Councilor District, is a resident of Warren and member of the host Society.

An outstanding program was presented with guest speakers from Vanderbilt University, Yale, University of Michigan, University of Texas, Lahey Clinic, Boston, Einstein Medical Center, Temple University, Johns Hopkins, University of Kentucky, as well as Ohio physicians.

A display of exhibits was one of the attractions.

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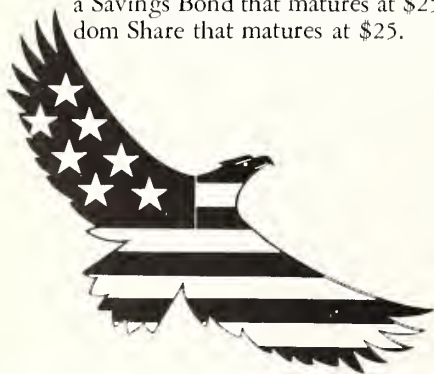
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Woman's Auxiliary Highlights . . .

By MRS. S. L. MELTZER, Chairman, Publicity Committee

2442 Dorman Drive, Portsmouth 45662

DOCTORS' WIVES can, on occasion, find themselves in the strangest of situations through no fault of their own. Now we have been caught between the pages of a book and —squashed! Even the title screeches "Doctors' Wives"; the publisher must feel there is money in them thar words! What is, perhaps, most confusing of all is the fact that the book was written by a doctor. (To be sure, he hasn't practiced in some 22 years, but he has managed to turn out over 50 books . . .)

That man is one Frank Slaughter, M.D. And to him, very recently, has gone a gem of a communication from the versatile and highly competent President of the Woman's Auxiliary to the Ohio State Medical Association — Mrs. J. Paul Sauvageot. Ludel Sauvageot is no slouch at the typewriter herself! She has a way with them thar words . . . Her letter to Dr. Slaughter is significant enough and important enough to be read by every doctor and every doctor's wife:

"Dear Dr. Slaughter: I am writing in regard to your new book, *Doctors' Wives*. Before I comment, I want to give you my background so you will see that I am not talking without knowledge, as you seem to be. Although I do not write officially, I am sure I voice opinions of most wives of physicians.

"My husband is a diplomate of the American Board of Internal Medicine and he and I have been married nearly 36 years. He has read your books (only after they come out in paperbacks) because he has been amazed how your accurate medical knowledge carries over into your novels. Perhaps your knowledge is limited to medicine, however, for it surely does not include medical auxiliaries.

"But back to me: I am a journalism graduate and was engaged in newspaper and public relations work

before being married. During World War II I did public relations for the Air Force while Dr. Sauvageot was in service. Since 1946 I have done hospital public relations, primarily for a large city hospital plus special state and national assignments. At present I am director of public affairs for the same hospital so I know doctors well, professionally, as well as socially. Most important of all, however, is the fact that I have been active in the medical auxiliary since I helped organize the Summit County (Ohio) group in 1941. As you can see from the letterhead I am using, I am now president of the Woman's Auxiliary to the Ohio State Medical Association, an office I did not seek but of which I am extremely proud. I have never had time to be a club woman or "joiner" but I feel being an auxiliary member is not only a privilege but it is a duty — and most enjoyable.

"During the past month I have had the distinct pleasure of working in various parts of the country with eight members of the Board of the Woman's Auxiliary to the American Medical Association. Mrs. Karl Ritter, national president, was in the group as was the national president-elect, Mrs. C. C. Long. I led a publications workshop since I was a contributing editor of *MD's Wife*, the national auxiliary magazine. It is sent to our nearly 100,000 members. Have you seen the magazine? If not, we might send you a few copies without charge so you can learn more about doctors' wives. Usually I am brief but I want you to realize I am in an excellent position to know about auxiliaries and wives of physicians.

"I wish you would tell us where any ambitious wife goes around getting votes pledged to back her for the presidency of her state auxiliary. Because state work is demanding of time, talents, and resources, finding qualified women to take responsibility

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is difficult. Becoming a national officer is not any more political than becoming a president on a state level and the office so many times more demanding. Love of work, sweat (not perspiration), great interest in our husband's profession and the ability to cooperate with one another combine to make auxiliary leaders on all levels. Your book notwithstanding, our morals are good, our marriage status honorable and we think our guys do all right by us.

"If you will look at the education and accomplishments of national auxiliary presidents and other leaders over the years, you will see how your lack of knowledge shows through pitifully in *Doctors' Wives*. As auxiliary members, we try to present a true image of ourselves as women dedicated to service in our communities and to our husbands' profession. Maybe, though, it would be easier to follow the pattern of your questionable characters, many of whom don't seem at all the type of women doctors I know marry.

"But maybe the doctors you know are different. If so, I'm glad they are your friends — not mine."

And on that sizzling note ends Ludel Sauvageot's letter to one author-physician who seemed bent on outdistancing Mary McCarthy and Her Group . . .

Meals on Wheels

That wonderful program, already being successfully done by some county auxiliaries here in Ohio and throughout the United States has a new recruit — Lucas County. It is such a worthwhile project that it seems fitting to feature it in this column and particularly at this season of the year. (And telling about it may also prove another answer to Dr. Slaughter!)

The Lucas County group, back in May of this year, heard with more than passing interest Miss Geraldine Piper, a nutrition consultant with the U. S. Public Health Service, as she unfolded stories of other Meals on Wheels programs. This afforded an opportunity to discuss HOW the Toledo area women could proceed with a similar undertaking. For those of you not familiar with this particular community service, the primary purpose of MEALS ON WHEELS is the provision of palatable meals that supply essential nutrients to a person who is unable to prepare or obtain adequate meals during a period of need or who is unable fully to understand and prepare a modified diet. This is a nonprofit, HOME-DELIVERED service.

Its objectives emphasize: (1) to help maintain or restore the individual's health; (2) to increase and maintain the highest state of independence as possible for the elderly, ill, and handicapped person; (3) to help the individual live as near a normal life as possible at home; (4) to help avoid institutionalization in the hospital or extended care facility; (5) to help shorten a hospital stay; and (6) to

hasten recuperation during a convalescent period after leaving the hospital or extended care facility.

Now setting up a program of this kind is no small job. As a matter of fact, it's a mighty big one. The Lucas County women set up what they called five task forces: **Food Service**—to explore all possible avenues in order to present specific recommendations with regard to type and number of meals, where and by whom these meals should be prepared, costs, and so on; **Packaging and Delivery**—to determine the most desirable and workable way of delivering hot and cold foods; **Screening and Eligibility**—to investigate and review policies to be determined in regard to eligibility, referral and payments; **Promotion and Publicity**—to explore and plan both short and long-range programs to inform the community thoroughly and understandably; and **Budget and Finance**—whose decisions are based on the findings of the other four task forces.

If you think this sounds like a complicated program, well—it is! Here in Ohio auxiliaries in Mansfield, Cleveland, Mt. Vernon, Columbus, and Dayton have proved it can be done—and done successfully. Toledo's Academy of Medicine has provided the use of a small room and desk in its building, to serve as a base for the administration of the new program. Arrangements have been made for the preparation and packaging of the food at St. Luke's Hospital. The first meals—to 24 subscribers—were delivered on December 4 by the volunteer workers who picked up the meals at the hospital and delivered them. Two people work as a team and each team delivers eight meals on a planned route. According to Lucas County president, Mrs. Howard Smith, this is a pilot project limited, for the time being, to the Old West End area. Later, it is planned to increase the service to other areas of the city. I have gone into some detail on this outstanding community effort because it is one that should interest many more auxiliaries!

Around the State

Four Allen County auxiliary members were honored recently by the *Lima News* women's department for outstanding contributions to their community: Mrs. A. A. Dalton, Mrs. J. M. McBride, Mrs. R. D. Rodabaugh and Mrs. Karl Ritter. This is the first time the local paper has come up with its "Women of Achievement" salute. The women are selected by a secret panel of judges after having been nominated by Lima and area clubs and individuals. Altogether, ten were honored—five for the "Women of Achievement" and five for Honorable Mention. In recognition, engraved plaques were presented by the paper.

Butler County has come up with something new and something provocative—and yet something old! It is called the Butler County Medical History Museum and it is housed in what is described as the

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"old Pfau Home." The museum is open from 1 to 5 P. M. on Tuesdays, Thursdays, Saturdays, and Sundays. (The old Pfau home is just around the corner from Mercy Hospital.) Harry Richmond, director of development for the hospital, master-minded the idea. Among the many intriguing items are: the unique will of a Hamilton doctor; such tasty tid-bits (ugh)! as calomel and assorted pills of various colors, smells and size; asafetida (would you confess to being old enough to have worn a bag around your neck??); an early vaporizer for whooping cough; nursery scales from 1904; an old book — "Cure for Smallpox"; an office sign in an old waiting room "Office Calls and Medicine — CASH"; a medical saddle bag; really old medical scales bought in Venice; a mechanical leech for blood letting; an 1883 book "Observations on the Deranged Manifestations of the Mind . . . or Insanity." There are many, many pieces of old-time doctors' equipment. What I have listed here is a tiny fraction of what is to be seen at this interesting collection.

The Lorain County auxiliary held a carnival and dinner party recently at the home of Dr. and Mrs. Robert Thomas for the purpose of raising money toward the group's pledge of \$1200 for the proposed Murray Riedge Center for the Retarded. Mrs. Gabriel Sabga served as general chairman, with Mrs. John McCoy and Mrs. William Miller serving as cochairmen. This carnival and dinner raised some \$400 — a mighty good start, I would say!

Merry Christmas

Rapidly approaching is that very special, very wonderful season of the year. On behalf of your state officers and state board, the warmest of greetings go to each and every one of you in the medical family. May the magic of Christmas remain with you all year long . . .

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Ad Astra

Franklin Cane Beeks, M. D., Oxford; University of Cincinnati College of Medicine, 1923; aged 72; died October 8; former member of the Ohio State Medical Association. A native of Oxford, and living in retirement there since 1960, Dr. Beeks practiced in several areas including Cincinnati and Portsmouth. He was a veteran of World War I, a member of the American Legion, the Elks Lodge, and the Masonic Lodge. His widow and a daughter survive.

Paul Webster Bowden, M. D., Richmond, Va.; University of Cincinnati College of Medicine, 1938; aged 54; died June 18. Dr. Bowden left Ohio shortly after completing his medical training in Cincinnati.

Albion Earl Brant, M. D., Youngstown; Jefferson Medical College of Philadelphia, 1912; aged 77; died October 2; member of the Ohio State Medical Association, the American Medical Association; American Geriatrics Society; Fellow of the American College of Surgeons; diplomate of the American Board of Surgeons. A native of Youngstown, Dr. Brant practiced medicine and surgery there over a period of half a century. He was long associated with the Youngstown Hospital Association, and was chief of surgery and chairman of the executive committee for many years. He is credited with many pioneering procedures in medicine and surgery. He was long active in affairs of the Mahoning County Medical Society and served as its president. During World War I, he was one of the organizers of Base Hospital 31, a group which distinguished itself overseas. He was also active in civic and fraternal affairs, was a member of the American Legion, several Masonic bodies, the chamber of commerce, the Christian Church, and numerous other organizations. Survivors include his widow, a daughter, a son, Dr. Earl E. Brant, of Larchmont, N. Y.; also three sisters.

Wayne Brehm, M. D., Columbus; Ohio State University College of Medicine, 1914; aged 77; died October 26; member of the Ohio State Medical Association, the American Medical Association, the American College of Obstetricians and Gynecologists; Fellow of the American College of Surgeons, and of the International College of Surgeons. Dr. Brehm was a practicing physician in Columbus over a half century, specializing in obstetrics and gynecology. In addition to his professional associations,

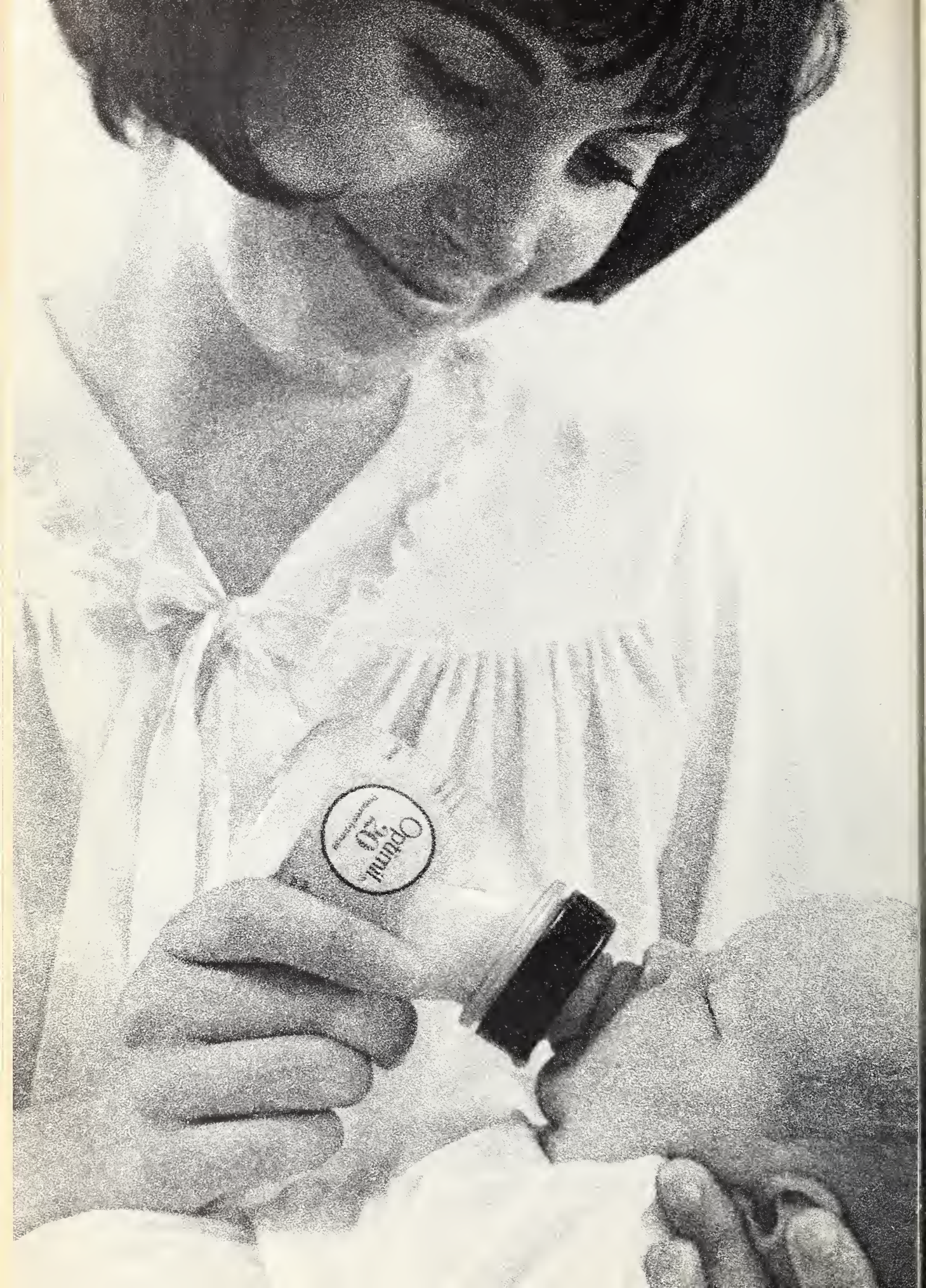
he was active in numerous civic, patriotic, and fraternal groups. He was a member of the American Legion, was chairman of the board of the Veterans Memorial Building since its inception, a member of the Navy League, the Chamber of Commerce, the Executive Club, several Masonic bodies, the Big Brothers Association, and others. Among survivors are his widow, a son Dr. Gill Brehm, of Sterling, Colorado, a daughter, and a brother.

Sander Cohen, M. D., Cincinnati; University of Cincinnati College of Medicine, 1931; aged 60; died October 28; member of the Ohio State Medical Association, the American Medical Association, American Society of Internal Medicine; Fellow of the American College of Physicians; diplomate of the American Board of Internal Medicine. A native of Cincinnati, Dr. Cohen served virtually all of his professional career there. He served in the Army Medical Corps during World War II and attained the rank of lieutenant colonel. He was a former president of the Cincinnati Society of Internal Medicine, and a member of the board of trustees for the Ohio Society of Internal Medicine. Survivors include his widow, a daughter, a son, his mother, a sister, and three brothers.

Nelson C. Dysart, M. D., Columbus; Ohio State University College of Medicine, 1908; aged 83; died October 23; former member of the Ohio State Medical Association. Dr. Dysart was Columbus health commissioner from 1929 to 1946. He was a veteran of World War I and after the war was associated with the American Red Cross with overseas assignments. A member of the Masonic Lodge, he is survived by his widow and a son.

Ross Moore Gault, M. D., Portsmouth; Ohio State University College of Medicine, 1928; aged 66; died October 7; member of the Ohio State Medical Association, the American Medical Association, and the American Academy of General Practice. Upon completion of his medical training, Dr. Gault returned to his native Portsmouth, where his father, the late Dr. William E. Gault, also practiced. Dr. Ross Gault practiced general medicine, and at one time was Scioto County coroner. He was a veteran of World War II, having served in the Air Force Medical Corps. Among affiliations, he was a mem-

(Continued on Page 1658)



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1. Hepner, R., et al.: *Pediatrics* 33:94, 1964. 2. Hepner, R., et al.: *Pediatrics* (to be published). 3. Hansen, A. E., et al.: *Pediatrics* 31:171, 1963. 4. Holman, R. T.: *Fed. Proceed.* 23:1062, 1964. 5. Holman, R. T., et al.: *Amer. J. Clin. Nut.* 14:83, 1964. 6. Young, R. J., and Garrett, R. L.: *J. Nut.* 81:321, 1963. 7. Hepner, R.: "New Perspectives on Nutritional Aspects of Modified Milk-Fat Formulas," a colloquium held under the auspices of The Pediatric Department, Western Reserve University School of Medicine, Cleveland, Ohio, Sept. 8, 1966. 8. Carson, M., and Hart, L.: *ibid.* 9. Nichols, M.: *ibid.*



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ber of the American Legion, the Elks Lodge, and the Presbyterian Church. Survivors include his widow, a daughter, and a son.

Thornton Greer Grimes, Sr., M. D., Springfield; Meharry Medical College, 1944; aged 51; died on or about September 18; member of the Ohio State Medical Association and the American Medical Association. An earlier resident of Springfield, Dr. Grimes returned there to practice in association with his uncle, the late Dr. Greer A. Allen. He was a member of the St. Teresa Church and the Kappa Alpha Phi Fraternity. Surviving are his widow, two sons, three daughters, and a sister.

Alfred Hudson Hendricks, M. D., Indiana University School of Medicine, 1908; aged 85; died October 25; former member of the Ohio State Medical Association and the American Medical Association. Dr. Hendricks retired in 1957 and made his home in Youngstown after approximately 50 years of practice and public health work. He was a general practitioner in Cleveland before he moved to Akron where he was associated with the Akron Board of Health, and where he worked with the school health program and the Well Baby Clinic. His widow survives.

Paul H. Jones, M. D., Stockdale; Ohio State University College of Medicine 1928; aged 66; died September 23; member of the Ohio State Medical Association and the American Geriatrics Society. A native of Pike County, Dr. Jones practiced in that vicinity for some 40 years. He also was county coroner for ten years. During World War II he served in the Army Medical Corps and attained the rank of colonel. Active in civic and fraternal affairs, he was affiliated with the National Association of Coroners, the Association of Military Surgeons, the county board of education, Boy Scout movement, Grange, the Masonic Lodge, and the Methodist Church. Among survivors are his widow, three daughters, and a step-daughter, a son, and four step-sons.

Paul Mortiz Kast, M. D., Akron; Faculty of Medicine, Friedrich-Wilhelms University, Prussia, 1922; aged 77; died October 14; member of the Ohio State Medical Association and the American Medical Association. A native of Germany and former practitioner in Europe, Dr. Kast came to this country in 1938 and the following year moved to Akron where he practiced, specializing in dermatology. His widow and a daughter survive.

John Maxwell McCleery, M. D., New Concord; Western Reserve University School of Medicine, 1917; aged 77; died October 26; member of the Ohio State Medical Association and the American Medical Association. Dr. McCleery retired in 1959 after some 35 years as Muskingum College physician. During World War I he served in the Army Medical Corps, and after the war entered the medical missionary field for the Presbyterian Church, under which he served in the Sudan until 1924. Two daughters survive.

Walter Orlando Mermis, M. D., Youngstown; St. Louis University School of Medicine, 1928; aged 63; died October 6; member of the Ohio State Medical Association, the American Medical Association, and the American Academy of General Practice. Dr. Mermis took his internship in Youngstown and returned there to practice after undergoing residency training in the East. His field was general practice and urological surgery. Among affiliations, he was a member of the Elks Lodge and the Catholic Church. Dr. William L. Mermis, formerly of Youngstown and now of Scottsdale, Arizona, is a brother. Also surviving is a son, another brother, and two sisters.

Roy Irving Peck, M. D., Philadelphia, Pa.; Western Reserve University School of Medicine, 1931; aged 60; died October 9; former member of the Ohio State Medical Association. Dr. Peck moved to Philadelphia in 1943 after practicing in Cleveland, Lakewood, and Bay Village. Among survivors are his widow, two sons, a daughter, two sisters, and a brother.

Mabel R. Tarbell, M. D., Columbus; Ohio State University College of Medicine, 1908; aged 81; died September 28; member of the Ohio State Medical Association, the American Medical Association, American Psychiatric Association and the American Geriatrics Society. One of pioneer women physicians in the area Dr. Tarbell began her practice in the general field and later specialized in psychiatry. For many years she practiced in association with her husband, Dr. Robert C. Tarbell who died in 1945. From 1949 until 1962 she was associated with the Veterans Administration as area chief of psychiatry for the Medical Division. A daughter survives.

Harry John Templeton, M. D., Carmel, California; Ohio State University College of Medicine, 1917; aged 72; died September 26. Dr. Templeton left Ohio early in his career to practice in the Western States. His widow and two daughters survive.

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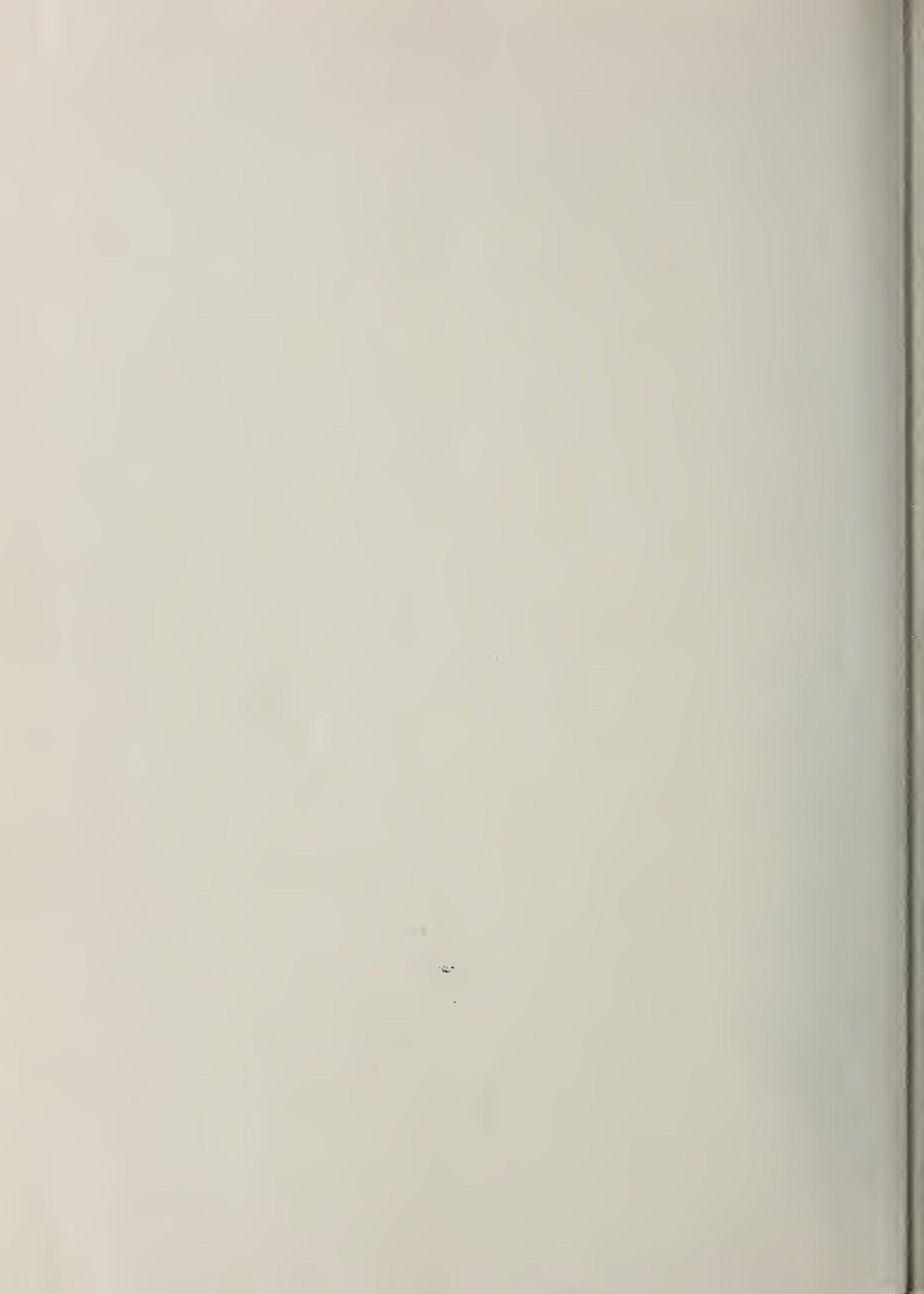
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